e. Any discrepancies identified during the pre-procedure verification process, shall require a "hard stop" and a "huddle" to be called at the patient's bedside to resolve the discrepancy.

F. TIME-OUT:

- 1. The Time Out is conducted immediately before starting the procedure.
- 2. During the Time Out, all other noise and activities in the room are suspended (to the extent possible, without compromising patient safety).
- 3. Use the medical record and patient armband to verify:
 - Patients' identity verified using two patient identifiers per Patient Care Services: Policy Identification of Patients Policy and comparing two sources of identification (patient's armband, if visible, and medical record). If the armband is not visible during the Time Out, one of the following alternatives must be used:
 - A patient identification band is placed on an exposed extremity (alterative wrist, ankle) and this band is used to confirm two patient identifiers during the Time Out.
 - ii. Two team members confirm the patient identity (two identifiers) upon arrival to the surgical/procedural area. One of the team members must remain with the patient during the entire pre-procedural phase and confirm the patient identity during the Time Out.
 - iii. Two team members confirm patient identity (two identifiers) upon arrival to the surgical/procedural area. The two patient identifiers are written on the white board in the procedure room and confirmed by the two team members. During the final Time Out, the team confirms patient identity against the information on the white board.
 - This patient identification process shall be used in surgical services.
 - b. Surgeon/LIPphysician/AHP calls for the Time Out after the patient is prepped and draped.
 - c. The circulating RN/assistive HCP (such as Emergency Medical Technician, Respiratory Care Practitioner, Radiology Technician, Anesthesia Technician):
 - i. Uses the consent form to read the patient's name, approved second identifier, and procedure. The circulating RN/HCP
 - **ii.** Verifies that the alcohol-based prep was allowed at least 3 minutes to dry and fumes to-dissipated before draping.
 - e.d. The anesthesiologist (if applicable, or circulating RN if no anesthesiologist present) states antibiotic administered, dose and time.
 - e. The circulating RN/assistive HCP-(such as Emergency Medical Technician, Respiratory Care Practitioner, Radiology Technician, Anesthesia Technician):
 - i. Verifies antibiotic selection is appropriate to procedure
 - ii. States antibiotic re-dosing interval
 - iii. Sets a timer for 30 minutes less than the re-dosing interval (i.e., if the re-dosing interval is 2 hours, set the timer for 1 hour and 30 minutes)
 - d.f. The surgeon/LIPphysician/AHP states the intended procedure, verifies the site is marked (if applicable) and asks if all agree.
 - e.g. The scrubbed person states agreement and readiness for consented procedure.
 - **f.h.** All Staff members in the OR at the time of the time out must state "I Agree" or state their concern/discrepancy.
- 4. Initiation of the Time Out is the responsibility of the surgeon/LIPphysician/AHP performing the procedure.
- 5. The Time Out is conducted in a fail-safe mode:
 - The surgery/invasive procedure is not started until all questions are resolved.
- 6. The time out includes all members of the procedural team who will be participating in the procedure at its inception.

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- 7. The circulating RN or healthcare provider assisting the LIP physician/AHP is responsible for documentation of the Time Out in the patient's medical record.
- 8. If two or more procedures are being performed on the same patient, a Time Out is performed to confirm each subsequent procedure before it is initiated.

G. RELATED DOCUMENT(S):

9-1. Patient Care Services: Identification of Patients Policy



Administrative Policy Patient Care

ISSUE DATE:

NEW

SUBJECT:

Decision Making for

Unrepresented Patients

REVISION DATE(S): NEW

POLICY NUMBER: 8610-397

Department Approval:

07/17

Administrative Policies and Procedures Committee Approval:

07/17

Medical Executive Committee Approval:

08/17

Professional Affairs Committee Approval:

Board of Directors Approval:

A. POLICY:

1. Preamble:

- a. This Tri-City Medical Center policy provides a process for health care professionals to make medical treatment decisions on behalf of an incapacitated patient who lacks a surrogate decision maker and when there is no known family member who is willing and able to make medical treatment decisions on behalf of the patient. Despite their incapacity, such "unrepresented" patients are entitled to have ethically and medically appropriate medical decisions made on their behalf and to have these decisions made in their best interest. The process set forth in this policy is intended to meet these goals. This policy is considered necessary since no clear-cut legal guidelines exist that cover these circumstances. This policy is designed to provide uniformity and consistency within the institutional setting of California's general acute care hospitals on the process to make medical treatment decisions for unrepresented patients.
- b. Decisions made without clear knowledge of an unrepresented patient's specific treatment preferences, must be made in the patient's best interest and taking into consideration the patient's personal history, values and beliefs to the extent that these are known. Decisions about treatment should be based on sound medical advice and should be made without the influence of material conflicts of interest. These decisions must be made with a focus on the patient's interests, and not the interests of providers, the institutions, or other affected parties. In this regard, appropriate health care decisions include both the provision of needed medical treatment and the avoidance of non-beneficial or excessively burdensome treatment, or treatment that is medically ineffective or contrary to generally-accepted health care standards.
- c. This policy is procedural in nature and applies to most medical decisions for which informed consent is usually required. This policy is meant to support the institution's underlying consent policy.
- d. Adoption of this policy does not preclude any party from seeking judicial intervention. Appropriate judicial remedies may include a timely court order authorizing the provision, withdrawing, or withholding of treatment or appointment of a conservator; however, courts are not necessarily the proper forum in which to make health care decisions.
- 2. When Use of This Policy is Appropriate:
 - a. This policy may be used when all of the following conditions are met:
 - i. The patient has been determined by the primary physician (with assistance from appropriate consulting physicians if necessary) to lack capacity to make health care decisions. Capacity means a patient's ability to understand the nature and consequences of proposed health care, including its significant benefits, risks,

and alternatives, and to make and communicate a health care decision. Conditions for which psychiatric or psychological treatment may be required do not, in and of themselves, constitute a lack of capacity to make health care decisions.

- ii. No agent, conservator, or guardian has been designated to act on behalf of the patient.
- iii. There is no individual health care directive or instruction in the patient's medical record or other available sources that would eliminate the need for a surrogate decision maker.
- iv. No surrogate decision maker or family member can be located who is reasonably available and who is willing and able to serve. Efforts to locate a surrogate should be diligent and may include contacting the facility from which the patient was referred, and contacting public health or social service agencies known to have provided treatment for the patient.
- 3. This policy does not address the criteria for determining and appointing an appropriate decision maker when one or more are available and willing to serve. And finally, this policy is not meant to be applied in emergency medical situations.

B. **PROCEDURE**:

- When use of this policy is appropriate, as outlined above, medical decisions will be made by a multi-disciplinary team whose members shall include, but not be limited to, individuals directly involved with the care of the patient.
- 2. It is recommended that the multi-disciplinary team include an attending physician, nurse familiar with the patient, social worker familiar with the patient, chair or vice-chair of the ethics committee, non-medical (community) member of the ethics committee or other appropriate committee and, if available and appropriate, consulting clinicians and pastoral care staff. It is very important to include on the multi-disciplinary team a person who will represent the patient's interests.
- 3. Some patients may have a family member or friend who is unable or unwilling to take full responsibility for making health care decisions on behalf of the patient, but who is willing to serve as part of this team. If no such person exists, the hospital may consider including an ombudsman, patient advocate, bioethicist, community member, or other person whose role is to protect the patients' interests. If it is not practicable to include such a person on the IDTmulti-disciplinary team in a particular case, document the reasons therefore.
- 4. In order to determine the appropriate medical treatment for the patient, the multi-disciplinary team should:
 - a. Review the diagnosis and prognosis of the patient and assure itself of the accuracy thereof.
 - b. Determine appropriate goals of care by weighing the following considerations:
 - i. Patient's previously-expressed wishes, if any and to the extent known
 - ii. Relief of suffering and pain
 - iii. Preservation or improvement of function
 - iv. Recovery of cognitive functions
 - v. Quality and extent of life sustained
 - vi. Degree of intrusiveness, risk or discomfort of treatment
 - vii. Cultural or religious beliefs, to the extent known
 - c. Establish a care plan based upon the patient's diagnosis and prognosis and the determination of appropriate goals of care. The care plan should determine the appropriate level of care, including categories or types of procedures and treatments.
 - d. Notify the patient that:
 - i. He or she has been determined incapacitated;
 - ii. It has been determined that he or she lacks a surrogate decision maker;
 - iii. Medical intervention has been prescribed; and

- iv. He or she has the opportunity to seek judicial review of the above determinations.
- e. A sample notification form is attached. Health care providers should modify it to fit their circumstances.
- **f.e.** If the patient will be administered antipsychotic drugs, consider obtaining the review of an independent physician.
- g.f. Limit end of life decisions (such as withholding or withdrawing life-sustaining treatment, ordering hospice care) to patients who are terminally ill, comatose, or in a persistent vegetative state.
- 5. Except to the extent that such a factor is medically relevant, any medical treatment decision made pursuant to this policy shall not be biased based on the patient's age, sex, race, color, religion, ancestry, national origin, disability, marital status, sexual orientation (or any other category prohibited by law), the ability to pay for health care services, or avoidance of burden to family/others or to society.
- 6. Under the terms of this policy, the multi-disciplinary team may make the same treatment decisions, and will have the same limitations, as does an agent appointed pursuant to a power of attorney for health care specified under current law.6,7 However, this policy shall not apply to decisions pertaining to disposition of remains, autopsies, or anatomical gifts; specific laws apply to these procedures.
- 7. The multi-disciplinary team must assure itself that the medical decision is made based on sound medical advice, is in the patient's best interest and takes into account the patient's values, to the extent known. In determining the best interest of the patient, it is not required that life support be continued in all circumstances, where treatment is otherwise non-beneficial or is medically ineffective or contrary to generally-accepted health care standards, when the patient is terminally ill and suffering, or where there is no reasonable expectation of the recovery of cognitive functions.
- 8. Agreement on Treatment:
 - a. If all members of the multi-disciplinary team agree to the appropriateness of providing treatment, it shall be provided.
 - b. If all members of the multi-disciplinary team agree to the appropriateness of withholding or withdrawing treatment, it shall be withdrawn or withheld. Any implementation of a decision to withhold or withdraw life-sustaining medical treatment will be the responsibility of the primary treating physician.
- 9. Disagreement on Treatment:
 - a. If the members of the multi-disciplinary team disagree about the care plan, the ethics committee, ethics resource expert(s) or other resource experts will meet with the team to explore their disagreement and facilitate resolution.
 - b. If agreement is reached either to provide or to forgo treatment, the decision of the multidisciplinary team then becomes final.
 - c. If agreement still is not reached, current treatments will be continued and any other medically necessary treatments provided, until such time that the issue is resolved through court intervention or the disagreement is otherwise resolved. Court-imposed legal remedies should be sought only in extreme circumstances and as a last resort.
 - d. In all cases, appropriate pain relief and other palliative care shall be continued.
- 10. Exceptional Circumstances:
 - a. Legal counsel should be consulted if a decision to withdraw or withhold treatment is likely to result in the death of the patient and the situation arises in any of the following circumstances:
 - i. The patient's condition is the result of an injury that appears to have been inflicted by a criminal act.
 - ii. The patient's condition was created or aggravated by a medical accident.
 - iii. The patient is pregnant.
 - iv. The patient is a parent with sole custody or responsibility for support of a minor child.

11. Documentation:

- a. Signed, dated and timed medical record progress notes will be written for the following:
 - The findings used to conclude that the patient lacks medical decision-making capacity.
 - ii. The finding that there is no advance health care directive, no conservator, guardian or other available decision maker, and no health care instructions in the patient's medical record or other available sources.
 - iii. The attempts made to locate surrogate decision makers and/or family members and the results of those attempts.
 - iv. The bases for the decision to treat the patient and/or the decision to withhold or withdraw treatment.
 - v. Any information from the ethics committee or other consult, should it be convened.

C. **REFERENCE(S)**:

- California Health and Safety Code Section 1418.8
- 2. California Probate Code Section 4735
- 3. California Probate Code Section 4650(c)
- 4. California Probate Code Section 4717
- California Probate Code Section 4736
- California Probate Code Section 4617
- 7. California Probate Code Section 4683
- 8. California Probate Code Section 4652
- 9. Health and Safety Code Sections 7100 (disposition of remains), 7113 (autopsy), and 7150 *et seg.* (anatomical gift).
- 10. California Probate Code Section 4734

Administrative Policy-Manual **District Operations**

TRACKED **CHANGES**

ISSUE DATE:

07/91

SUBJECT: MANDATORY REPORTING

REQUIREMENTS

POLICY NUMBER: 8610-236

REVISION DATE: 12/91, 11/94, 02/95, 03/96, 04/97,

07/99, 06/02, 05/03, 07/09, 06/11

Department Approval:

12/1604/17

Administrative Policies & Procedures Committee Approval:

02/1504/17

Organizational Compliance Committee Approval:

08/17

Medical Executive Committee Approval: Professional Affairs Committee Approval:

03/15

Board of Directors Approval:

03/15

A. **PURPOSE:**

- To objectively and systematically monitor and evaluate quality and appropriateness of patient care, pursue opportunities to improve patient care, assure patient safety and resolve identified quality/risk issues on an ongoing basis. To identify and prevent serious-injury, actual or potential. harm to a patient or visitor of Tri-City Health Care District (TCHD). Incident reporting enhances the quality of patient care and reduces healthcare and medical liability.
- This policy/procedure consists of the following areas for reporting: 2.
 - Adverse Unexpected Events
 - Sentinel Events b.
 - C. Serious Reportable Events
 - Unusual Occurrences (Title 22)
- For Violence Against Hospital Personnel see Administrative Policy: Assault and Battery d.3. Reporting Process 241.
- PURPOSE: The purpose of this section is to describe the nature of a sentinel event and to e.4. provide a process for identifying, investigating, and reporting sentinel events.

B. **DEFINITION(S):**

- Adverse Events: A patient safety event that results in harm to a patient including surgical events, product or device events, patient protection events, care management events, environmental events, and criminal events.
- 2. Near Miss/Close Call: A patient safety event that did not reach the patient; also called good catch.
- f.3. Root Cause Analysis - is a process for identifying the-basic or causal factor(s) that-underlyingies variation in performance, including the occurrence or possible occurrence of a sentinel event.
- 4. Sentinel Events: A patient safety event (not primarily related to the natural course of the patient's illness or underlying condition) that reaches a patient and results in death, permanent harm, or severe temporary harm. Sentinel events are a subcategory of adverse events.
- 5. Serious Reportable Events: as developed by the National Quality Forum see National Quality Forum List of Serious Reportable Events 2011.
- Unusual Occurrences (Title 22): Any occurrence such as epidemic outbreak, poisoning, g.6. fire, major accident, disaster, other catastrophe or unusual occurrence with threatens the welfare, safety or health of patients, personnel or visitors.
- Violence Against Hospital Personnel: acts of assault or battery against on-duty hospital 3.7. personnel.
- Sentinel Event: is an unexpected occurrence involving death or serious physical or psychological

injury, or the risk thereof. Serious injury specifically includes loss of limb or function. The phrase, "or the risk thereof" includes any process variation that for which a recurrence would carry a significant chance of a serious adverse outcome [sometimes referred to as a "near miss"].

- The sentinel event definition includes any occurrence that meets any of the following criteria:
 - i. The event has resulted in an unanticipated death or major permanent loss of function, not related to the natural course of the patient's illness or underlying condition, or;
 - ii. The event is one of the following (even if the outcome was not death or major permanent loss of function unrelated to the natural course of the patient's illness or underlying condition):
 - 1) Suicide of any patient receiving care, treatment or services in a staffed around the clock care setting or within 72 hours of discharge
 - 2) Unanticipated death of a full-term infant
 - 3) Abduction of any patient receiving care, treatment or services
 - 4) Discharge of an infant to the wrong family
 - 5) Sexual abuse, including rape
 - 6) Hemolytic transfusion reaction involving administration of blood or blood products having major blood group incompatibilities
 - 7) Invasive procedure or surgery on the wrong patient, wrong procedure, or wrong site.
 - 8) Unintended retention of a foreign object in a patient after surgery or other invasive procedure
 - 9) Severe neonatal hyperbilirubinemia (bilirubin greater than 30 mg/dL)
 - 10) Prolonged fluoroscopy with cumulative dose greater than 1500 rads to a single field, or any delivery of radiotherapy to the wrong body region or greater than 25% above the planned radiotherapy dose.
- 5. Near Miss_is a term used to describe any process variation which did not affect the outcome but for which a recurrence carries a significant chance of serious adverse outcome.

 Serious Reportable Event as developed by the National Quality Forum see National Quality Forum List of Serious Reportable Events 2011.

6.C. POLICY:

- a.1. It is the District's policy to investigate any sentinel event, unusual occurrence, serious adverse event, or serious reportable even"near miss" from an interdisciplinary perspective and take action to reduce the risk of recurrence. Each serious adverse event
 - i-a. Each sentinel event, unusual occurrence, adverse event, and serious reportable event will be intensively assessed through the use of the Root Cause Analysis (RCA) process. An action plan, based on the RCA is developed to implement improvements to reduce risk; the action plan is implemented and the effectiveness monitored.
 - b. Every effort will be made to include the physicians and staff involved in the incident in the RCA process.
 - c. The Risk Manager or Senior Administrative Designee shall coordinate the implementation of the improvement or correction plan, the monitoring of the effectiveness of the plan and reporting of progress to the Executive Council.
 - d.c. A report of each RCA shall be communicated to the Quality Assurance/Performance Improvement/Patient Safety Committee (QA/PI/PS) of the Medical Staff, for periodic reporting to the Board of Directors throughvia the Professional Affairs Committee (PAC) and Board of Directors meeting.
 - e.d. RCAs shall not be reported to the Joint Commission, nor to any external agency or organization, except upon specific, written advice of legal counsel. The Sentinel Event investigation and reporting process, including development of the RCA, is intended to remain within the bounds of Medical Staff Peer Review, subject to all applicable protections from discovery, including Evidence Code § 1157 and Attorney-Client and Attorney Work Product privileges.

7. PROCESS:

- a. Each sentinel event, unusual occurrence, adverse event, and serious reportable eventpotential sentinel event will be investigated to the extent necessary to determine all the relevant facts and circumstances. The Risk Manager or Senior Administrative Designee shall compare the facts and circumstances to the Sentinel Event definition, and make a preliminary determination whether the potential event appears to qualify as a sentinel event. In order to make this determination, the Risk Manager or Regulatory DirectorSenior Administrative Designee has the discretion to convene an Ad Hoc committee, composed of physicians, hospital staff and consultants, if necessary, to assist in determining if a sentinel event has occurred.
 - i. If the potential event is determined to qualify as a sentinel event, the RCA process commences immediately and shall be completed within 45 days of notification of the event.
 - If the potential event fails to qualify as a sentinel event, the matter may be closed or referred for additional study using performance improvement methods.
 - ii. The RCA shall be documented on a "Root Cause Analysis" form and made part of a permanent file to be maintained by the Risk Manager. The RCA shall not be filed in the Medical Record.
- The RCA report's conclusions and recommendations, if any, shall be communicated to the involved departments/services for development of a plan of action or plan of correction.
- The Director of Risk Management and/or the Director of Regulatory Compliance, or Senior Administrative Designee shall coordinate the implementation of the improvement or correction plan, .t The monitoring of the effectiveness of the plan and reporting of progress to the Administrative Team Meetingwill be reported to the Quality Assure Performance Improvement (QA/PI) Committee.

8.D. REPORTING TIMEFRAMES:

- a.1. The first person to identify an **incident**adverse event will notify his/her supervisor as soon as it is safe to do so.
 - b.a. The supervisor must assure that **the incidents**erious adverse events is are reported the Director of Risk Management, Chief Nurse Executive, and the Director of Regulatory Compliance. These **CNE** will assure that the event is then reported to the Chief Executive Officer, and Chief Operating Officer, etc as appropriate prior to reporting to regulatory agencies.
- e.2. The patient's primary and/or involved physician(s) is notified.
- 2.3. Based on the incident circumstances, a decision will be made to report the event to the appropriate regulatory agencyies within the required timeframe. All events requiring notification of regulatory agencies, such as the California Department of Public Health, will be completed in a timely manner.
 - a. The appropriate Medical-Staff Leader for the department is notified.

B.E. COMMUNICATION:

- a. Information related to the reportable event is communicated to the physician and staff involved in the care of the patient as soon as possible.
- b. Physicians and staff involved in the reportable event may will be included in the RCA and Action Plan.
- c. The appropriate Medical Staff Leader will be notified prior to reporting the event whenever possible.
- d.1. Reported **incidents** are communicated to the appropriate medical staff Quality Review committees, the Medical Executive Committee, and the Board of Directors.
- e.2. IncidentsCritical events may be reported in an expedited manner by Administration via verbal or electronic methods.

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Board of Directors via the Professional Affairs Committee (PAC)<u>UNUSUAL OCCURRENCES (TITLE 22)</u> <u>DEFINITIONS:</u>

Unusual Occurrence: (Title 22, Section 70736) - any condition or event which has jeopardized, or could jeopardize, the health, safety, security or well being of any patient, employee or any other person while in the facility. These shall include, but not be limited to the following:

An epidemic outbreak of any disease, prevalence of communicable disease, whether or not such disease is required to be reported by Title 17, California Administrative Code, Section 2500, or epidemic infestation by parasites or vectors

Poisonings

Fires

Physical injury to any person, which would require treatment by a physician

Death of a patient, employee or visitor from unnatural causes

Sexual acts involving patients who are non-consenting

Physical assaults on patients, employees or visitors

All instances of patient abuse

Actual or threatened walkout, or other curtailment of services or interruption of essential services provided by the facility

PROCEDURE:

In accordance with State of California standards, the following previsions have been established. An occurrence such as epidemic-outbreak, poisoning, fire, major accident, disaster, other catastrophe or unusual occurrence which threatens the welfare, safety or health of patients, personnel or visitors, shall be reported as soon as reasonably practical, either by telephone or by any other practical means to the local health officer and to the California Department of Public Health (CDPH) and as applicable to county of San Diego Behavioral Health Services or the Department of Health Care Services.

The District shall furnish other pertinent information related to such occurrences as may be required by CDPH or health officers.

In the event of a disruption of services, the Administrator or designee shall be responsible for immediate reporting.

ADVERSE UNEXPECTED EVENTS:

<u>PURPOSE:</u> This section complies with the requirements of SB 1301 (CA Health & Safety Code §§ 1279.1, 1279.2, 1279.3, and 1280.4) mandating the reporting of "adverse events" to the California Department of Public Health (CDPH).

POLICY:

It shall be the policy of Tri-City Medical Center (TCMC) to report an adverse event, as defined in Health & Safety Code § 1279.1, to the CDPH and as applicable to county of San Diego Behavioral Health Services or the Department of Health Care Services not later than 5 days after the adverse event has been detected; or, in the event of an ongoing urgent or emergent threat to the welfare, health, or safety of patients, personnel or visitors, not later than twenty four (24) hours after the adverse event has been detected. TCMC shall inform the patient or the party responsible for the patient of the adverse event by the time the report to CDPH is made.

PROCESS:

All adverse events shall be reported without delay to the Director of Risk Management and to the Director of Regulatory Compliance, or in their absence, to the COO, CNE, or in his/her absence, to the CEO for analysis and determination if such adverse event needs to be reported to CDPH and as applicable to county of San Diego Behavioral Health Services or the Department of Health Care Services. The Director of Risk Management shall notify the attending physician(s) and the Chief of Staff, or his designee, that a report of a potential adverse event has been received. These physicians and the CEO, CNE,COO or their designees shall be consulted and provide input regarding the report ability of the event, so long as such consultation and input does not prevent timely reporting to CDPH and as applicable to county of San Diego Behavioral Health Services or the Department of Health Care Services. In the event that an adverse event qualifies for reporting to CDPH, the report shall be made on a form, specifically designed for such reporting and individually identifiable patient information shall be safeguarded, in terms of privacy and confidentiality, consistent with applicable law. In every situation, the attending physician shall be the preferred individual to disclose the adverse event to the patient/family. Only where the attending physician is unable to or unwilling to make this disclosure will a Medical Staff Officer, or some other designee, disclose the event to the patient/family. The date, time, and circumstances

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of disclosure shall be recorded in the patient's permanent medical record.

The Department Director/Manager/designee shall be notified of the event. In addition, if the patient is a research patient, the Director of Clinical Research shall be notified.

The Director of Risk Management is responsible for ensuring that a thorough investigation of the adverse event is completed, which may include a root cause analysis.

The adverse significant event shall be reported in the in the RL Solutions Incident Report.

CALIFORNIA STATE REPORTABLE ADVERSE EVENTS:

Surgical events, including the following:

Surgery performed on a wrong body part that is inconsistent with the documented informed consent for that patient. A reportable event under this subparagraph does not include a situation requiring prompt action that occurs in the course of surgery or a situation that is so urgent as to preclude obtaining informed consent. Surgery performed on the wrong patient.

The wrong surgical procedure performed on a patient, which is a surgical procedure performed on a patient that is inconsistent with the documented informed consent for that patient. A reportable event under this subparagraph does not include a situation requiring prompt action that occurs in the course of surgery, or a situation that is so urgent as to preclude the obtaining of informed consent.

Retention of a foreign object in a patient after surgery or other procedure, excluding objects intentionally implanted as part of a planned intervention and objects present prior to surgery that are intentionally retained. Death during or up to 24 hours after induction of anesthesia after surgery of a normal, healthy patient who has no organic, physiologic, biochemical, or psychiatric disturbance and for whom the pathologic processes for which the operation is to be performed are localized and do not entail a systemic disturbance.

Product or device events, including the following:

Patient death or serious disability associated with the use of a contaminated drug, device, or biologic provided by the health facility when the contamination is the result of generally detectable contaminants in the drug, device, or biologic, regardless of the source of the contamination or the product.

Patient death or serious disability associated with the use or function of a device in patient care in which the device is used or functions other than as intended. For purposes of this subparagraph, "device" includes, but is not limited to, a catheter, drain, or other specialized tube, infusion pump, or ventilator.

Patient death or serious disability associated with intravascular air embolism that occurs while being cared for in a facility, excluding deaths associated with neurosurgical procedures known to present a high risk of intravascular air embolism.

Patient protection events, including the following:

An infant discharged to the wrong person.

Patient death or serious disability associated with patient disappearance for more than four hours, excluding events involving adults who have competency or decision-making capacity.

A patient suicide or attempted suicide resulting in serious disability while being cared for in a health facility due to patient actions after admission to the health facility, excluding deaths resulting from self-inflicted injuries that were the reason for admission to the health facility.

Care management events, including the following:

A patient death or serious disability associated with a medication error, including, but not limited to, an error involving the wrong drug, the wrong dose, the wrong patient, the wrong time, the wrong rate, the wrong preparation, or the wrong route of administration, excluding reasonable differences in clinical judgment on drug selection and dose.

A patient death or serious disability associated with a hemolytic reaction due to the administration of ABO-incompatible blood or blood products.

Maternal death or serious disability associated with labor or delivery in a low-risk pregnancy while being cared for in a facility, including events that occur within 42 days post-delivery and excluding deaths from pulmonary or amniotic fluid embolism, acute fatty liver of pregnancy, or cardiomyopathy.

Patient death or serious disability directly related to hypoglycemia, the onset of which occurs while the patient is being cared for in a health facility.

Death or serious disability, including kernicterus, associated with failure to identify and treat hyperbilirubinemia in neonates during the first-28 days of life. For purposes of this subparagraph, "hyperbilirubinemia" means bilirubin levels greater than 30 milligrams per deciliter.

A Stage 3 or 4 ulcers, acquired after admission to a health facility, excluding progression from Stage 2 to Stage

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3 if Stage 2 was recognized upon admission.

A patient death or serious disability due to spinal manipulative therapy performed at the health facility. Environmental events, including the following:

A patient death or serious disability associated with an electric shock while being cared for in a health facility, excluding events involving planned treatments, such as electric counter shock.

Any incident in which a line designated for oxygen or other gas to be delivered to a patient contains the wrong gas or is contaminated by a toxic substance.

A patient death or serious disability associated with a burn incurred from any source while being cared for in a health facility.

A patient death associated with a fall while being cared for in a health facility.

A patient death or serious disability associated with the use of restraints or bedrails while being cared for in a health facility.

Criminal events, including the following:

Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed health care provider.

The abduction of a patient of any age.

The sexual assault on a patient within or on the grounds of a health facility.

The death or significant injury of a patient or staff member resulting from a physical assault that occurs within or on the grounds of a facility.

An adverse event or series of adverse events that cause the death or serious disability of a_patient, personnel, or visitor.

Serious Disability means a physical or mental impairment that substantially limits one or more of the major life activities of an individual, or the loss of bodily function, if the impairment or loss lasts more than 7 days or is still present at the time of discharge from an inpatient health care facility, or the loss of a body part.

C.F. ATTACHMENT(S):

- Reporting Grid
- 2. National Quality Forum List of Serious Reportable Events 2011

G. RELATED DOCUMENTS:

3.1. Administrative Policy: Assault and Battery Reporting Process 241

D.H. REFERENCES:

- 1. CA Health & Safety Code §§ 1279.1, 1279.2, 1279.3, and 1280.4
- 4.2. California Code of Evidence Section 1157
- 3. California Hospital Association Consent Manual 201614
- 4. Title 17
- 5. Title 22, Section 70736

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Reporting Grid

teaction (ADR) ICH guidance for Clinical Septembrian Physician/Principal Safety Data Management Physician/Principal Safety Data Management Physician/Principal Safety Data Management Coordinator Clinical Trial/Sub Investigator of Clinical Trial Sub Investigator of Clinical Trial/Sub Investigator of Clinical Trial/Clinical Research Coordinator Section 920 Security Department, Business Office Registrars, Social Service Department, CCR Trite 11, Section 920 Security Department, Section 2593 Infe Oncology Data Registrar Security Risk Management Section 10101 Medical Records Department Local Law Enforcement Child Cab Coordinator Child Care Custodian Child Care Custodian	CIRCUMSTANCE	REGULATION STATUTE	ву wном	то wном	WHEN/HOW	TCMC REFERENCE POINT OR PROTOCOL
Attending Physician/Principal Investigator of Clinical Trial, Sub Investigator of Clinical Trial/Clinical Research Coordinator Emergency Department, Humane Society Business Office Security Department, Professional & Regulatory Services (P&RS), Employee Health, Dept. of Health Nursing Staff, Security. Risk Management Oncology Data Registrar California Department of Public Health (CDPH) Birth Certificate Clerk San Diego County Registrar Medical Records Department Social Service Department Child Protective Services or Health Practitioner, Child Care Custodian Child Care Custodian	Adverse Drug Reaction (ADR)		Attending Physician/Investigational Drug Pharmacists/Principal Investigator of Clinical Trial/ Sub Investigator of Clinical Trial/Clinical Research Coordinator	Clinical Trial Site/Principal Investigator of Clinical Trial, Sub Investigator of Clinical Trial/Clinical Research Coordinator	All ADRs must be documented in the research participants medical and research record.	Policy: Clinical Research Subject Safety & AE/SAE/Incident Reporting Policy; Policy number #010
Pusiness Office Ty to On-Duty A.B. #508 CA Penal Code # 240,242 CA Penal Code # 240,242 CCR Title 11, Section 920 Social Service Department, CCR Title 11, Section 920 Social Service Department, Nursing Staff, Security, Risk Management Beylations, Section 2593 Social Service Department, California Department of Public Health (CDPH) Cancer Prevention Section 10101 Birth Certificate Clerk Section 10101 Birth Certificate Clerk Section 10101 Social Service Department Child Protective Services or Health Practitioner, Child Protective Services or Health Practitioner, Child Care Custodian Child Abuse Emergency Department California Department of Public Health CDPH) Cancer Prevention Section Birth Certificate Clerk Section 10101 California Department of Child Protective Services or Health Practitioner, Child Care Custodian	Adverse Event (AE)	for	Attending Physician/Principal Investigator of Clinical Trial/ Sub Investigator of Clinical Trial/Clinical Research Coordinator	Clinical Trial Site/Principal Investigator of Clinical Trial, Sub Investigator of Clinical Trial/Clinical Research Coordinator	Aes are to be captured in the case report forms and as part of the medical records. There are no special reporting requirements for AEs at TCMC.	Policy: Clinical Research Subject Safety & AE/SAE/Incident Reporting Policy; Policy number
Tocal Law Enforcement Professional & Regulatory Services (P&RS), Employee Health Dept. of Health Dept. of Health Professional & Regulatory Services (P&RS), Employee Health Code 11160/11161 Emergency Department, CA Penal Code 11160/11161 Emergency Department, CA Penal Code 11160/11161 Emergency Department, Nursing Staff, Security, Risk Management Management Regulations, Section 2593 Cocology Data Registrar Section 10101 Emergency Department of Public Health (CDPH) Cancer Prevention Section 10101 Medical Records Department Child Protective Services or Health Practitioner, Local Law Enforcement Child Care Custodian	Animal Bites		Emergency Department, Business Office	Humane Society	Phone Call	Emergency Dept.
CCR Title 11, Section 920 Social Service Department, Nursing Staff, Security, Risk Management Regulations, Section 2593 Ith Health and Safety Code Section 10101 Business Office Registrars, Social Service Department, Nursing Staff, Security, Risk Management California Department of Public Health (CDPH) Cancer Prevention Section Medical Records Department Medical Records Department Child Protective Services or Health Practitioner, Child Care Custodian Coal Law Enforcement California Department of Public Health (CDPH) Cancer Prevention Section California Department of Public Health (CDPH) Cancer Prevention Section California Department of Public Health (CDPH) Cancer Prevention Section California Department of Public Health (CDPH) Cancer Prevention Section California Department of Public Health (CDPH) Cancer Prevention Section California Department of Public Health (CDPH) Cancer Prevention Section California Department of Public Health (CDPH) Cancer Prevention Section California Department of Public Health (CDPH) Cancer Prevention Section California Department of Public Health (CDPH) Cancer Prevention Section California Department of Public Health (CDPH) Cancer Prevention Section California Department of Public Health (CDPH) Cancer Prevention Section California Department of Public Health (CDPH) Cancer Prevention Section California Department of Public Health (CDPH) Cancer Prevention Section California Department of Public Health (CDPH) Cancer Prevention Section California Department of Public Health (CDPH) Cancer Prevention Section California Department of Public Health (CDPH) Cancer Prevention Section California Department of Public Health (CDPH) Cancer Prevention Section California Department of Public Health (CDPH) Cancer Prevention Section California Department of Public Health (CDPH) Cancer Prevention Section California Department of Public Health (CDPH) Cancer Prevention Section California Department of Public Health (CDPH) Cancer Prevention Section California Department of Publ	Assault & Battery to On-Duty Health Care Personnel	A.B. #508 CA Penal Code # 240,242	Security Department	Local Law Enforcement Professional & Regulatory Services (P&RS), Employee Health, Dept. of Health	Phone Call within 72 hours of occurrence. Employee Injury Report	Admin. Policy #241
Title 17, California Code of Regulations, Section 2593 Regulations, Section 2593 Regulations, Section 2593 Regulations, Section 2593 Regulations, Section 2604 Regulations, Section 2607 Regulations, Section 2607 Regulations, Section 2607 Regulations, Section 3 Section 3 Social Service Department Child Protective Services or Health Practitioner, Local Law Enforcement Child Care Custodian	Assault Victims Domestic Violence		Emergency Department, Business Office Registrars, Social Service Department, Nursing Staff, Security, Risk Management	Local Law Enforcement	Phone police immediately and written report - 2 working days	Admin. Policy #310
Health and Safety Code Section 10101 Penal Code: 11164-11174.3 Redical Records Department Penal Code: 11164-11174.3 Social Service Department Health Practitioner, Child Care Custodian	Cancer/Reportable Neoplasms	Title 17, California Code of Regulations, Section 2593	Oncology Data Registrar	California Department of Public Health (CDPH) Cancer Prevention Section	Within six months of diagnosis	Oncology Registry/CNE
Penal Code: 11164-11174.3 Social Service Department Child Protective Services or Health Practitioner, Local Law Enforcement Child Care Custodian	Certification of Birth	Health and Safety Code Section 10101	Birth Certificate Clerk Medical Records Department	San Diego County Registrar	Within 10 days of birth	Medical Records Dept.
	(Suspected) Child Abuse	Penal Code: 11164-11174.3	Social Service Department Health Practitioner, Child Care Custodian	Child Protective Services or Local Law Enforcement	Immediately by Phone-And Within 36 Hours in Writing	Admin. Policy #308 Social Service Dept. #308

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CIRCUMSTANCE	REGULATION STATUTE	ВҮ WНОМ	то wном	WHEN/HOW	TCMC REFERENCE POINT OR PROTOCOL
Chromosomal Defects in Fetus or Infant	Title 17 CCR 6532	Lab performing the analysis or physician making diagnosis	СДРН	Within 30 days of diagnosis using form provided by CDPH	Women's & Children's Services
(Illegal) Drug Use - non employee	CA Penal Code, Section 11- 160	Security Dept.	Oceanside Police	Telephone and written report	Admin. Policy #236
(Suspected) Elder and Dependent Adult Abuse	Penal Code: Section 368 Welfare & Institution Code #1560015637	Social Service Department Health Practitioner, Care Custodian	Occurring in a LTC Facility report to Long Term Care Ombudsman or Local Law Enforcement; All others to County Adult Protective Services	Telephone Report- Immediately Written Report- Within 2 Working Days	Admin. Policy #309 Social Service Dept. #309
Infectious Diseases (Reportable *) (See Reporting Responsibility Table)	Title 17, Chapter 4, CCR 2500 Health & Safety Code 3125	Nursing Staff Emergency Department, Infection Control Practitioner, Laboratory - Microbiology & Chemistry	Infection Control Practitioner Public Health Department	Phone immediately to Public Health depending on disease. Fax information to Public Health using PM 110.	Infection Control #110
Lapses in Consciousness/Seizures	Health & Safety Code 3125 Section 410 Title 17, CCR 2500	Physician	Local Health Officer who reports to DMV	Fax information to Public Health using PM 110.	Physician Protocol
Mental Health holds beyond 24 hours (ED) (Unusual Occurrence)	Title 22 Section 70737, 71535	Health Care Practitioner Administration Manager Emergency Department	СОРН	Phone after 24 hour mark followed by letter to CDPH	Emergency Dept., Mental Health Unit
Missing Patient		Security Department	Local Law Enforcement Agencies	Telephone immediately within reasonable time frame (given situation)	Admin. Policy #305
Multiple bee stings (Unusual occurrence)	Title 22 CCR 70737	Emergency Department Nursing Staff	County of San Diego, CDPH	Phone call immediately to CDPH written report	Admin. Policy #228
Needle stick Injury/BS Exposure	Fed and Cal OSHA Rec. Blood borne Path.	Supervisor	Employee Health or ED	Immediate Supervisor Investigative Report. Employee Health uses separate injury log for needle sticks.	Employee Health Services/ Infection Control

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CIRCUMSTANCE	REGULATION	ВҮ WНОМ	то wном	WHEN/HOW	TCMC REFERENCE POINT OR PROTOCOL
Neural Tube Defects in a Fetus	Title 17, California Code of Regulations, Section 6531	Medical Records Department	CDPH Alpha-Feto Protein Screening Program	Within 30 days of initial diagnosis	Women's & Children's Services
Newborn Abandonment: Voluntary surrender (abandonment of newborns up to 72 hours old)	SB 1368	Health Care Practitioner	Child Protective Services	As soon as possible; no later than 48 hours	Admin. Policy #380
Newborn Screening Test refusal (PKU)		Women's & Children's Services Representative	CDPH Genetic Disease Branch	Prior to infant discharge Fill out form #NBS-PR	Women's & Services
Occupational Injuries/Illnesses	Labor Code 3209.3 CCR Title 8 S - 14003	Physician	Employer & Employees Insurer	Written Report within 5 working days	Physician Protocol Employee Health Services
Outbreaks or undue prevalence of infectious or parasitic disorder	Title 17, Chapter 4 CCR 2502	Any healthcare provider (physicians, PA, RN, nurse midwife, or Infection Control Practitioner)	Local Health Officer	Phone, fax or mail information to Public Health using the CMR form found in the IC Manual.	Infection Control #IC.12
Patient Death	Title 22 72549 HSC 10250	Health Care Practitioner; Physician	Medical Examiner CDPH at a time and manner as requested, Pt. Reps – TCMC	Phone immediately Complete form 8720-37	PCS Policy IV.Z , PCS Procedure
Patient death due to unusual circumstances, i.e. suicide	Title 22 Section 70737, 71535	Health Care Practitioner Administration	Local law enforcement officer, medical examiner and CDPH.	Local law enforcement contacted prior to medical examiner. CDPH as soon as practical confirmed in writing. Incident report on file by facility for 1 year.	Admin Policy #228 PCS Policy IV.Z , PCS Procedure
Patient death while patient in seclusion or restraint for behavior management	42 CFR Section 482.13(f)(f) Reporting is required whether or not R/S was the cause of death Title 22, CCR Section 70737(a) Section 71535	Director of Regulatory Compliance	Centers for Medicare and Medicaid Services (CMS) CDPH	As soon as aware. By telephone: (415) 744-3726 or fax (415) 744-2692	Admin Policy #228 PCS Policy IV.Z , PCS Procedure

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CIRCUMSTANCE	REGULATION STATUTE	ву wном	то wном	WHEN/HOW	TCMC REFERENCE POINT OR PROTOCOL
Patient death while in medical surgical restraint	Title 22, CCR, Section 70737(a) Section 71535	Director of Regulatory Compliance	сорн	As soon as reasonably practical, by phone: (800) 824-0613 Followed by letter: 7575 Metropolitan Drive Suite 104 San Diego, CA 92108	PCS Policy IV.Q
Patient Injury/Death due to Device Malfunction	Safe Medical Device Act 21 CFR 803	Health Practitioner Director of Risk Management	-MFR-Serious Injury FDA&MFR-Death or FDA if MFR is unknown	Within 24 hours via form FDA3500A and phone 301-796- 6670. E. mail: MDRPOLICY@FDA,HHS.G OV Annual Summary of Medical Device Related Death and Serious Injury Report to FDA on Form FDA 3419 by January 1** of each year as described in 803.33	Admin. Policy #201
Patient Transfer Violation	(COBRA) Health and Safety Code 1317 through 1317.99 Title 42 U.S.C. Section 139 dd	Director of Regulatory Compliance	СDРН НСFA	7 days 72 hours	Admin. Policies 228, 506; PCS Policy VI.D
Pesticide Poisoning	Title 8 CCR 14003	Emergency Department Health Care Practitioner	Emergency Department Mgr. Local Health Officer Co. Dept. of Agric. Deputy Agricultural Commissioner	Phone call within 24 hours	Emergency Dept.
PKU Specimen not obtained		Unit Representative where infant was a patient	California Department of Public Health Genetic Disease Branch	When patient transferred, expires Fill out form # (BS - No - 90)	Women's & Children's Services
Rhesus Hemolytic (RH) Disease – Newborn	Title 17 CCR Section 6510 Title 22 CCR 70737	Health Care Practitioner	CDPH - Women's & Children's Services Office physician who made diagnosis	Use reporting form "A case report of RH Disease of Newborn"	Women's & Children's Services
Reye Syndrome	HSC Section 304.5	Attending Physician	СDРН	Within 7 days of diagnosis using reporting form "CBC Reye Syndrome"	Physician Protocol

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CIRCUMSTANCE	REGULATION STATUTE	BY WHOM	ТО WHOM	WHEN/HOW	REFERENCE POINT OR PROTOCOL
Serious Adverse Event (SAE) as related to Clinical Research	ICH guidance for Clinical Safety Data Management: Definitions and Standards for Expedited Reporting	Attending Physician/Principal Investigator of Clinical Trial/ Sub Investigator of Clinical Trial	Clinical Trial Site/Principal Investigator/Sub Investigator/Clinical Research Coordinator	Report Immediately to Attending Physician and Clinical Trial Site personnel. All SAEs must be documented in the research participants medical and research record.	Policy: Clinical Research Subject Safety & AE/SAE/Incident Reporting Policy, Policy number #010
Threat to kill	Tarasoff	Psychotherapist/Health Care Practitioner	Intended victim and local law Immediately by telephone enforcement	Immediately by telephone	Behavioral Health Unit, Social Service Dept.
Unusual occurrences that threaten the welfare of the patient, staff or visitors (i.e., allegation of staff sexual misconduct)	Title 22 Section 70737, 71535	Health Care Practitioner Administration Director of Regulatory Compliance	CDPH Local law enforcement as appropriate	As soon as reasonably practical - confirmed in writing Occurrence on file by facility for 1 year	Admin. Policy #228
Adverse effect of a vaccine	National Childhood Vaccine Injury Act	Health Care Provider	VAERS Hotline 800-822- 7967	After administration by telephone	Infection Control

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National Quality Forum List of Serious Reportable Events - 2011

1. SURGICAL OR INVASIVE PROCEDURE EVENTS

1A. Surgery or other invasive procedure performed on the wrong site (updated)

Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

1B. Surgery or other invasive procedure performed on the wrong patient (updated)

Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

1C. Wrong surgical or other invasive procedure performed on a patient (updated)

Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

1D. Unintended retention of a foreign object in a patient after surgery or other invasive procedure (updated)

Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

1E. Intraoperative or immediately postoperative/postprocedure death in an ASA Class 1 patient (updated)

Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices

2. PRODUCT OR DEVICE EVENTS

2A. Patient death or serious-injury associated with the use of contaminated drugs, devices, or biologics provided by the healthcare setting (updated)

Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

2B. Patient death or serious-injury associated with the use or function of a device in patient care, in which the device is used or functions other than as intended (updated)

Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

2C. Patient death or serious injury associated with intravascular air embolism that occurs while being cared for in a healthcare setting (updated)

Applicable in: hospitals, outpatient/office-based surgery centers, long-term care/skilled nursing facilities

3. PATIENT PROTECTION EVENTS

3A. Discharge or release of a patient/resident of any age, who is unable to make decisions, to other than an authorized person (updated)

Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

3B. Patient death or serious-injury associated with patient elopement (disappearance) (updated)

Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

3C. Patient suicide, attempted suicide, or self-harm that results in serious-injury, while being cared for in a healthcare setting (updated)

Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

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4. CARE MANAGEMENT EVENTS

4A. Patient death or serious-injury associated with a medication error (e.g., errors involving the wrong drug, wrong dose, wrong patient, wrong time, wrong rate, wrong preparation, or wrong route of administration) (updated)

Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

4B. Patient death or serious-injury associated with unsafe administration of blood products (updated)

Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

4C. Maternal death or serious injury associated with labor or delivery in a low-risk pregnancy while being cared for in a healthcare setting (updated)

Applicable in: hospitals, outpatient/office-based surgery centers

4D. Death or serious-injury of a neonate associated with labor or delivery in a low-risk pregnancy (new)

Applicable in: hospitals, outpatient/office-based surgery centers

4E. Patient death or serious injury associated with a fall while being cared for in a healthcare setting (updated)

Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

4F. Any Stage 3, Stage 4, and unstageable pressure ulcers acquired after admission/presentation to a healthcare setting (updated)

Applicable in: hospitals, outpatient/office-based surgery centers, long-term care/skilled nursing facilities

4G. Artificial insemination with the wrong donor sperm or wrong egg (updated)

Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices

4H. Patient death or serious injury resulting from the irretrievable loss of an irreplaceable biological specimen (new)

Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

4I. Patient death or serious-injury resulting from failure to follow up or communicate laboratory, pathology, or radiology test results (new)

Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

5. ENVIRONMENTAL EVENTS

5A. Patient or staff death or serious injury associated with an electric shock in the course of a patient care process in a healthcare setting (updated)

Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

5B. Any incident in which systems designated for oxygen or other gas to be delivered to a patient contains no gas, the wrong gas, or are contaminated by toxic substances (updated)

Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

5C. Patient or staff death or serious-injury associated with a burn incurred from any source in the course of a patient care process in a healthcare setting (updated)

Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based

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practices, long-term care/skilled nursing facilities

5D. Patient death or serious-injury associated with the use of physical restraints or bedrails while being cared for in a healthcare setting (updated)

Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

6. RADIOLOGIC EVENTS

6A. Death or serious-injury of a patient or staff associated with the introduction of a metallic object into the MRI area (new)

Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices

7. POTENTIAL CRIMINAL EVENTS

7A. Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed healthcare provider (updated)

Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

7B. Abduction of a patient/resident of any age (updated)

Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

7C. Sexual abuse/assault on a patient or staff member within or on the grounds of a healthcare setting (updated)

Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

7D. Death or serious-injury of a patient or staff member resulting from a physical assault (i.e., battery) that occurs within or on the grounds of a healthcare setting (updated)

Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities



Administrative Policy **District Operations**

CLEAN COPY

ISSUE DATE:

07/91

SUBJECT: MANDATORY REPORTING

REQUIREMENTS

REVISION DATE: 12/91, 11/94, 02/95, 03/96, 04/97,

POLICY NUMBER: 8610-236

07/99, 06/02, 05/03, 07/09, 06/11

Department Approval:

04/17

Administrative Policies & Procedures Committee Approval:

04/17

Organizational Compliance Committee Approval:

08/17

Professional Affairs Committee Approval:

03/15

Board of Directors Approval:

03/15

A.

- To objectively and systematically monitor and evaluate quality and appropriateness of patient care, pursue opportunities to improve patient care, assure patient safety and resolve identified quality/risk issues on an ongoing basis. To identify and prevent injury, actual or potential, harm to a patient or visitor of Tri-City Health Care District (TCHD). Incident reporting enhances the quality of patient care and reduces healthcare and medical liability.
- 2. This policy/procedure consists of the following areas for reporting:
 - Adverse Events a.
 - Sentinel Events b.
 - Serious Reportable Events C.
 - Unusual Occurrences (Title 22)
- 3. For Violence Against Hospital Personnel – see Administrative Policy: Assault and Battery Reporting Process 241.

B. **DEFINITION(S):**

- 1. Adverse Events: A patient safety event that results in harm to a patient including surgical events, product or device events, patient protection events, care management events, environmental events, and criminal events.
- Near Miss/Close Call: A patient safety event that did not reach the patient; also called good 2. catch.
- 3. Root Cause Analysis - is a process for identifying basic or causal factor(s) underlying variation in performance, including the occurrence or possible occurrence of a sentinel event.
- 4. Sentinel Events: A patient safety event (not primarily related to the natural course of the patient's illness or underlying condition) that reaches a patient and results in death, permanent harm, or severe temporary harm. Sentinel events are a subcategory of adverse events.
- 5. Serious Reportable Events: as developed by the National Quality Forum see National Quality Forum List of Serious Reportable Events 2011.
- Unusual Occurrences (Title 22): Any occurrence such as epidemic outbreak, poisoning, fire, 6. major accident, disaster, other catastrophe or unusual occurrence with threatens the welfare. safety or health of patients, personnel or visitors.
- Violence Against Hospital Personnel: acts of assault or battery against on-duty hospital 7. personnel.

C.

It is the District's policy to investigate any sentinel event, unusual occurrence, adverse event, or serious reportable even from an interdisciplinary perspective and take action to reduce the risk

of recurrence.

- a. Each sentinel event, adverse event, and serious reportable event will be intensively assessed through the use of the Root Cause Analysis (RCA) process.
- b. Every effort will be made to include the physicians and staff involved in the incident in the RCA process.
- c. A report of each RCA shall be communicated to the Quality Assurance/Performance Improvement/Patient Safety Committee (QA/PI/PS) of the Medical Staff, for periodic reporting to the Board of Directors through Professional Affairs Committee (PAC) and Board of Directors meeting.
- d. RCAs shall not be reported to the Joint Commission, nor to any external agency or organization, except upon specific, written advice of legal counsel. The investigation and reporting process, including development of the RCA, is intended to remain within the bounds of Attorney-Client and Attorney Work Product privileges.

D. **REPORTING TIMEFRAMES:**

- 1. The first person to identify an incident will notify his/her supervisor as soon as it is safe to do so.
 - a. The supervisor must assure that the incident is reported the Director of Risk Management, Chief Nurse Executive, and the Director of Regulatory Compliance. The CNE will assure that the event is then reported to the Chief Executive Officer, and Chief Operating Officer prior to reporting to regulatory agencies.
- 2. The patient's primary and/or involved physician(s) is notified.
- 3. Based on the incident, a decision will be made to report to the appropriate regulatory agency within the required timeframe.

E. COMMUNICATION:

- Reported incidents are communicated to the appropriate medical staff Quality Review committees and the Board of Directors.
- 2. Incidents may be reported in an expedited manner by Administration via verbal or electronic methods.

F. ATTACHMENT(S):

- 1. Reporting Grid
- 2. National Quality Forum List of Serious Reportable Events 2011

G. **RELATED DOCUMENTS**:

Administrative Policy: Assault and Battery Reporting Process 241

H. REFERENCES:

- 1. CA Health & Safety Code §§ 1279.1, 1279.2, 1279.3, and 1280.4
- 2. California Code of Evidence Section 1157
- 3. California Hospital Association Consent Manual 2016
- 4. Title 17
- 5. Title 22, Section 70736

Administrative Policy-Manual District Operations

ISSUE DATE:

01/07

SUBJECT: POLICY AND PROCEDURE

APPROVAL - ADMINISTRATIVE

PROCESS

REVISION DATE: 07/09, 07/12

POLICY NUMBER: 8610-240

07/17

Department Approval:

Administrative Policies & Procedures Committee Approval:

07/1507/17

Professional Affairs Committee Approval:

08/15

Board of Directors Approval:

08/15

A.

To define Tri-City Healthcare District's (TCHD) process for the approval of policies.

B. **DEFINITION(S):**

- Policy/Procedure: A policy is a formal, approved, written description of how a governance. management, or clinical care process is defined, organized, or carried out. A policy covers broad principles or complex standards requiring Board/Administrative approval and may have significant legal, regulatory, or financial implications.
 - Documents that may support the policy/procedure; including but not limited to practices, procedures, pre-printed orders, and chart forms; are not defined for the purposes of this policy.

C. **POLICY:**

- The electronic policy management system will be used for all policies and procedures.
- Policies/procedures are: 2.
 - Required-To be reviewed I-or revised perevery five (5)three years or as required by change in regulation regulatory requirements, research, or organizational processes and submitted through the approval process.
 - See Policies and Procedures Review Grid.
 - It is recommended that policies/procedures be reviewed / revised every three (3) years. Nursing policies and procedures are required to be reviewed every three (3) years per Title 22.
 - Standardized procedures are required to be reviewed every two (2) years per California Board of Registered Nurses.
 - Neonatal Unit policies are required to be reviewed per California Children Services (CCS).
 - Laboratory.
 - Interpretation policy required to be reviewed annually per the Joint Commission (JC).
 - Environment of Care plans are required to be reviewed annually per the JC.
 - Developed in collaboration with the medical staff; if relevant to medical staff activities a.b. and/or direct patient care.
 - b.c. DevelopedAnd in collaboration with nursing leadership if relevant to direct patient care.
 - Consistent with professional references, applicable regulations, legal requirements, a.d. accreditation standards, and the mission and philosophy of the organization.
- 3. Creating and revising documents:

- e.a. The editable version (i.e. Word document) will be stored in the electronic policy management system.
- b. Revisions to the documents will be tracked as changes while going through the approval process.
- d.c. Any changes to content, deletions, and/or combining of policies/procedures will require the full approval process.

4. Approval:

- b-a. Policies/Procedures are submitted to the Board of Directors (BOD) or Administration for final approval.
 - i. All policies are submitted to the Board of Directors for final approval.
 - ii. Procedures are submitted to the BOD or Administration for final approval based on regulatory requirements.
 - 1) Nursing procedure must be approved by the BOD per Title 22
 - i-iii. Pre-approved by Board Committees prior to submission to the Board:
 - 1) The Human Resource Committee (HRC) approves all administrative policies that relate to human resource issues.
 - The Finance, Operations, and Planning Committee (FO&P) approves all administrative policies that relate to finance issues.
 - 3) The Audit, Compliance and Ethics Committee (ACE) approves all administrative policies that relate to compliance and privacy issues.
 - 4) The Governance/Legislative Committee approves all policies that relate to the Board of Directors issues, Medical Staff By-Laws and Medical Staff Rules and Regulations.
 - 5) The Professional Affairs Committee (PAC) approves all others.
- b. Issue Date should be the first final approval date by BOD or Administration.
- c. Revision dates should reflect final approval dates every additionaleach time the policy/procedure is approved by the Board/Administration.
- 2.d. The Department Manual Coordinating Committee will coordinate approval at Medical Staff Department/Division/Committees, Medical Executive Committee (MEC), Board Committees and the BOD.
- e. Staff shall be notified of any new policies/procedures or significant revisions. Education shall be provided as appropriate.
- e.f. A hard copy of all current policies/procedures must be available in the department for downtime.

D. PROCESS FOR ADMINISTRATIVE MANUAL(S) APPROVAL:

- 1. Approval Process
 - a. Content Expert
 - b. Administrative Policies and Procedures Committee (APP)
 - c. Pharmacy and Therapeutics Committee (P&T), if contains medication, medication administration or if standardized procedure
 - d. MEC, if relevant to medical staff activities and/or direct patient care
 - e. Appropriate Board Committee
 - f. BOD

E. PROCESS FOR PATIENT CARE SERVICES (PCS) MANUAL APPROVAL:

- 1. Approval Process
 - a. Content Expert
 - b. Clinical Policies and Procedures Committee (CPP)
 - c. Nurse Executive Committee (NEC)
 - d. Medical Staff/Department Division, if relevant to medical staff activities or direct patient care
 - e. P&T, if contains medication, medication administration or if standardized procedure
 - f. Interdisciplinary Practice Committee (IDPC), if a standardized procedure

- g. MEC, if relevant to medical staff activities and/or direct patient care
- h. PAC
- i. BOD

F. PROCESS FOR DEPARTMENT SPECIFIC MANAUL APPROVAL:

- 1. Approval Process
 - a. Content Expert
 - b. Department Manager and/or Director
 - c. Medical Director for clinical areas with a Medical Director when appropriate
 - d. Medical Staff/Department Division, if relevant to medical staff activities or direct patient care
 - e. MEC, if relevant to medical staff activities and/or direct patient care
 - f. PAC
 - a. BOD
- 2. Each Department is responsible for maintaining their own department specific manual.
 - a. Makes revisions in the electronic policy management system to policies/procedures using tracked changes.
 - a.b. Obtain Medical Director's approval if applicable for policies/procedures related to Medical Staff activities or direct patient care.

G. RELATED DOCUMENT(S):

b.1. Policies and Procedures Review Grid

H. REFERENCE(S):

- 1. California Department of Public Health, Title 22 California Code of Regulations
- 2. The Joint Commission Standards
- 3. California Children's Services Standards
- 4. College of American Pathologists

Policies and Procedures Review Grid

Policies and Procedures Category	Policy/Procedure Name	Review Period	Regulation Requirement
Nursing Policies	All	3 Years	Title 22
Standardized Procedures	All	2 Years	California Board of Registered Nurses
Neonatal Unit Policies	All	2 Years	California Children Services (CCS)
Laboratory Policies	All	2 Years	College of American Pathologists (CAP)
Interpretation Policies	Patient Care Services: Interpretation and Translation Services Policy	Annual	Joint Commission (JC)
Environment of Care Plans	Engineering: Utility Management Plan Environment of Care: Hazardous Material and Waste Management and Communication Plan Environment of Care: Life Safety Management Plan Environment of Care: Safety Plan Environment of Care: Security Management Plan	Annual	Joint Commission (JC)
Pharmacy: Sterile Pharmaceuticals and	Pharmacy: Automatic Therapeutic Interchange Pharmacy: Black Box Warnings, Drugs with Policy	Annual	TCHD Pharmacy and Therapeutics Committee
Hazardous Drugs	Pharmacy: Sterile Products Preparation	Annual	United States Pharmacopeia (USP) <797>,<800>
Infection Control	Infection Control: Aerosol Transmissible Diseases and Tuberculosis Control Plan IC 11 Infection Control: Bloodborne Pathogen Exposure Control Plan Infection Control Infection Control: Risk Assessment and	Annual	

Behavioral Health Services Inpatient Behavioral Health Unit Crisis Stabilization Unit

SUBJECT:

Abuse Reporting Forms

POLICY NUMBER: 700

ISSUE DATE:

03/08

REVISION DATE: 08/09, 06/10, 03/13

Department Approval:

03/17

Division of Psychiatry Approval:

Pharmacy and Therapeutics Approval:

06/17

Pharmacy and Therapeutics Approval:

n/a 08/17

Medical Executive Committee Approval: Professional Affairs Committee Approval:

Board of Directors Approval:

A. PURPOSE:

1. To ensure that all forms related to reporting abuse are properly completed and filed.

B. **POLICY:**

 When it becomes necessary to report dependent adult abuse or neglect, the clinician will follow established hospital policy and will complete and file all relevant forms in a uniform and consistent manner.

C. PROCEDURE:

- 1. Social Services:
 - a. When calling either Child Protective Services (CPS) or Adult Protective Services (APS) the name of the person contacted will be documented in the medical record.
 - b. The original form will be mailed/faxed to the agency. If the form is faxed, a fax confirmation must be obtained.
 - c. A copy of the form along with the fax confirmation will be forwarded to Tri-City Healthcare District's (TCHDTCMC) Case Management/Social Service office.
 - d. No copies will be placed in the medical record.
- 2. Psychiatric Liaison Team:
 - a. As with Social Services, the Psychiatric Liaison filing a CPS or APS report will document the name of the person contacted in the medical record.
 - b. The original form will be mailed/faxed to the agency. If the form is faxed, a fax confirmation must be obtained.
 - c. A copy of the form along with the fax confirmation will be forwarded to the BHU Nurse educator who will forward it to the TCHDTCMC Case Management/Social Service office.
 - d. No copies will be placed in the medical record.



EDUCATION DEPARTMENT MANUAL

SUBJECT:

AHA: NON-TCHDTCMC CLASS PARTICIPANTS

ISSUE DATE:

03/07

REVISION DATE(S): 04/10, 07/13

Department Approval:

12/1603/17

Medical Executive Committee Approval:

n/a

Professional Affairs Committee Approval:

Board of Directors Approval:

07/13

A. PURPOSE:

- 1. To utilize **Tri-City Healthcare District (TCHD)TCMCTCHD** existing education resources (AHA Instructors)
- 2. To practice fiscal responsibility and generate revenue.

B. **DEFINITION(S)**:

- 1. Non-TCMCTCHD employee.
- 2. Basic Life Support Renewal (BLS), Advanced Cardiac Life Support (ACLS), and Pediatric Advanced Life Support (PALS). Full, Renewal, and Skills courses.

C. POLICY:

- 1. The TCMCTCHD AHA Training Center (TC) coordinates the number and frequency of AHA courses based on information provided by Human ResourcesRes-Q database.
- 2. AHA scheduled courses not filled by TCMCTCHD employees will be made available to Non-TCMCTCHD employees in order to manage staffing and prevent cancellation of TC Instructors.
 - a. Courses will be made available to Non-TCMCTCHD employees 1 (one) week prior to BLS renewal course and one (1) week prior to ACLS courses.
- 3. Non—TCMCTCHD Employees must present a current AHA BLS/ACLS Provider and/or Instructor card from an approved AHA Training Center that is current and in good standing with the AHA guidelines and curriculum.
- 4. TCMCTCHD TC will accept cards only from the American Heart Association's Healthcare Provider Online Renewal course if it included a complete Part II skills check from an authorized AHA Training Center.
- 5. TCMCTCHD TC will utilize the Course Card Reference Guide for surveillance of AHA provider cards which is found in TC Coordinator's office.
- Contact Education department for most current list of Training Centers in good standing with the AHA.
- 2.6. When a scheduled course does not have a complete participant allotment or if an opening exists due to cancellation of participants, TCMCTCHD will offer the course to a requesting Non-Employee
 - a. The Non-TCMCTCHD employee will be notified within one week for BLS courses and within 1 week for ACLS courses to allow for recommended course preparation
 - b. The Non-TCMCTCHD employee candidate will adhere to the AHA guidelines for course preparation, utilizing the most current AHA course materials
 - c. The Non- TCMCTCHD employee confirms attendance and payment must be made in full upon enrolling, payment may be made with cash, er-check or credit card.
- 6.7. The costs for Non-Employee AHA course participation ((Attachment A) are as follows:
 - a. BLS provider (accelerated)renewal- (not including BLS Provider Manual): \$6050.00

Education Department-Policy Manual AHA -Non-TCHDTCMC Class Participants Page 2 of 3

- b. BLS provider full course (not including BLS Provider Manual): \$60.00
- a.c. BLS skills (not including BLS Provider Manual): \$30.00
- b.d. ACLS and PALS renewal- (not including ACLS Provider Manual): \$150.00
- e.e. ACLS and PALS full course- (not including ACLS Provider Manual): \$200.00
- f. ACLS and PALS Skills sessions \$60
- d.8. AHA course student manuals are required for all instructor-led events. Students must have a manual before, during and after the course.
- 7.9. All costs will be refunded if course is canceled by TCMCTCHD AHA TC
- **8.10.** Cancellation by the student less than 2 working days prior to the class are subject to \$50 administrative fee.
- 9.11. No shows will forfeit 100% of course fees

D. **FORM(S)**:

AHA Class Price List

E. <u>REFERENCE(S) LIST:</u>

1. American Heart Association Program Administration Manual

F. APPROVAL PROCESS

- 1. Clinical Policies & Procedures Committee
- Nurse Executive Council
- 3. Professional Affairs Committee
- 4. Board of Directors

Education Department-Pelicy-Manual AHA -Non-TCHDTCMC Class Participants Page 3 of 3

| AHA CLASS PRICE LIST

AHA CLASS PRICE LIST

As TCMC refunds all employees the cost of classes, 2 receipts are required – 1 for class and 1 for manual. Wellness Center employees receive a refund for BLS classes.

Name of Class	TCMC Employees Refunded	Staff MDs / Travelers	Staff MDs/ Travelers w/o Manual	Non- TCMC	Non- TCMC w/o Manual	Manuals Only
BLS Full Course - Blue Instruction Sheet	\$25.00	\$65.00	\$50.00	\$65.00	\$50.00	\$15.00
BLS Renewal - Tan Instruction Sheet	\$25.00	\$55.00	\$40.00	\$55.00	\$40.00	\$15.00
BLS Skills - Green Instruction Sheet	\$25.00	\$30.00	\$30.00	\$30.00		
BLS Skills Online Key		\$18.00	\$18.00	\$18.00	\$18.00	\$18.00
ACLS Full Course – Salmon Instruction Sheet	\$50.00	\$200.00	\$170.00	\$225.00	\$195.00	\$30.00
ACLS Renewal Course Lavender Instruction Sheet	\$50.00	\$120.00	\$90.00	\$150.00	\$120.00	\$30.00
Heartsaver AED Community Class – Red Instruction Sheet (\$35.00 for class if they saw our ad in the newspaper)				\$65.00	\$50.00	\$15.00
NRP Renewal (Full Courses not offered)	\$25.00	\$100.00	\$50.00	\$100.00	\$50.00	\$50.00
PALS Full Course – Green Instruction Sheet	\$50.00	\$210.00	\$175.00	\$210.00	\$175.00	\$35.00
PALS Renewal – Green Instruction Sheet	\$50.00	\$135.00	\$100.00	\$135.00	\$100.00	\$35.00
ENPC Full Course – Pink Instruction Sheet	\$50.00		\$175.00		\$175.00	Loaner
ENPC Renewal – Pink Instruction Sheet	\$50.00		\$100.00		\$100.00	Loaner

* Includes Manual

All students signing up for ACLS/BLS classes must receive instruction sheet.

EDUCATION DEPARTMENT-MANUAL

SUBJECT:

DESCRIPTION OF PROFESSIONAL EDUCATION DEPARTMENT

ISSUE DATE:

03/03

REVISION DATE(S): 07/05, 08/07, 04/10, 07/13

Department Approval:

03/17

Medical Executive Committee Approval:

n/a

Professional Affairs Committee Approval:

Board of Directors Approval:

8/07; 4/10; 7/13

A. POLICY:

- 1. Scope of Services:
 - a. The Education Department's scope of services provided to the organization consists of employee orientation, in-service education, continuing education, leadership and organizational development, project facilitation.
- 2. Operational Initiatives:
 - a. The Education Department's operational initiatives are developed each year based on the organization's hospital wide operational plan.
 - b. Quarterly, the operation plan is updated regarding status and accomplishments and reported by the Director of Education, and-Clinical Informatics and Staffingen to the Chief Nurse Executive (CNE).
- 3. Physical Location:
 - a. The Education Department offices are located on the lower level of the Pavilion below the main lobby area. The classrooms are adjacent to the offices. The Medical Staff Library is located on 1North.
 - b. Storage of the Education Department's equipment and supplies are located in closets in the Assembly Rooms.
 - c. Archived education files are indexed and stored off site if older than 1 year.
- 4. Hours of Operation:
 - a. The hours of the Education Department are 7:30 am 4:00 pm, Monday through Friday with the exception of organization-defined holidays and by appointment.
 - b. The Computer Labs in classroom 4 and classroom 8 can be accessed from 7:30 am 4:00 pm.
 - e.i. The computer room in classroom 4 is available afterhours for completion of net learning modules by contacting **Tri-City Healthcare District (TCHDMC)** Security at 760-940-3367.

B. APPROVAL PROCESS

- 1. Clinical Policies & Procedures Committee
- Nurse Executive Council
- 3. Professional Affairs Committee
- Board of Directors

EDUCATION DEPARTMENT-MANUAL

SUBJECT:

IN-SERVICE EDUCATION

ISSUE DATE:

06/03

REVISION DATE(S): 08/07, 04/10, 07/13

Department Approval:

03/17

Medical Executive Committee Approval:

n/a

Professional Affairs Committee Approval:

Board of Directors Approval:

07/13

| A. **POLICY:**

- In-service education consists of those activities that assist personnel to fulfill assigned responsibilities specific to the performance standards of the work units. These activities are conducted internal to the facility and are directed at current standards.
- 2. The aim of inservice is to maintain competency (in relation to existing standards); create new competency (in relation to newly developed standards); respond to Performance Improvement findings (convert non-compliance to compliance); and introduce/review equipment.
- Inservice for new products and equipment is initiated by the Clinical Value Analysis Committee 3. whose membership includes an Education staff member.
- 4. The company vendor/representative contacts the Education Department to plan the most effective means of inservice training.
- Leadership and Management may request inservice education to meet the individual practice 5. needs of the work unit by contacting the education staff.

APPROVAL PROCESS

- Clinical Policies & Procedures Committee
- Nurse Executive Council
- Professional Affairs Committee 3.
- Board of Directors 4.

EDUCATION DEPARTMENT POLICY MANUAL

SUBJECT: `

MISSION AND VISION OF THE EDUCATION DEPARTMENT

ISSUE DATE:

03/03

REVISION DATE(S): 07/05, 08/07, 04/10, 03/12, 07/13

Department Approval:

03/17

Medical Executive Approval:

n/a

Professional Affairs Approval:

Board of Directors Approval:

07/13

A. **MISSION STATEMENT:**

To provide innovative educational experiences that advance the knowledge and skills of all Tri-City Medical CenterHealthcare District (TCHDMC) employees to promote excellence.

B. VISION STATEMENT

Create an environment to support evidence based practices by delivering education through progressive learning modalities.

C. PROFESSIONAL EDUCATION DEPARTMENT:

- Mentors and supports lifelong learning
- 2. Promotes research and evidence-based practice
- 3. Integrates technological advances into practice
- Facilitates Multi-disciplinary collaborations 4.
- 5. Acts as resource to community
- 6. Serves as academic liaisons
- 7. Develops professional practice
- 8. Facilitates Interdisciplinary in-house/community education
- 9. Provides:
 - Initial and ongoing assessment of staff skills, knowledge, behaviors and ability to provide a. patient care
 - b. Continuing Education (CE) classes/programs
 - Certification, orientation, computer training C.
 - d. Annual competencies/Skills ValidationLab
 - Proactive mandatory training/Netlearning e.
 - CE/Tuition reimbursement f.
 - g. Standards for basic competency/training
 - h. Direct clinical research support staff through Information Specialist
 - Supports disease specific care certification and maintanencemaintenance programs i.
- 10. Assists organization in meeting regulatory standards

APPROVAL PROCESS

- Clinical Policies & Procedures Committee
- **Nurse Executive Council**
- **Professional Affairs Committee** 3.
- 4. **Board of Directors**



MEDICAL STAFF-POLICY MANUAL

ISSUE DATE:

10/04

SUBJECT:

Election Process of Member(s)

at Large for the Medical Executive

Committee

REVISION DATE(S): 04/08, 08/12

POLICY NUMBER: 8710 – 531

Department Approval:

Medical Staff Committee Approval: Pharmacy and Therapeutics Approval:

Medical Executive Committee Approval: Professional Affairs Committee Approval:

Board of Directors Approval:

03/1707/17

n/a n/a

03/1708/17

04/17 04/17

Α. **PURPOSE:**

To provide direction for the nomination and election process for the Member(s) at Large position on the Medical Executive Committee.

B. PROCEDURE:

- All Active Medical Staff members of may submit their names to the Medical Staff Office two months prior to the June General Staff Meeting.
- Interested Active Medical Staff members are required to complete a Conflict of Interest form 2. before being added to the ballot.
- 3. Candidates will be provided the opportunity to speak at the General Staff Meeting.
- 4. Voting will be by ballot.
- A quorum of voting members is required to elect Members-at-Large. 5.
- Each voting member will be allotted two votes. A member may vote twice for any one candidate 6. or vote once for any two candidates or withhold one or both votes.
- 7. For a Member-at-Large to be elected, the candidate must be the candidate receiving the most votes. If there are two vacancies being elected, then the candidates receiving the highest and second highest number of votes cast will win.
 - If one or both of the available Member-at-Large Medical Executive seats are not filled, the seat(s) will remain vacant.
- Vacant seat(s) after original appointment on the Medical Executive Committee shall remain 8. vacant until the next June General Medical Staff Meeting.
- 9. Members-at-Large will serve a ene-two year term and no member shall serve more than two successive terms.



Outpatient Behavioral Health Services

SUBJECT: Admission to Inpatient Behavioral Health Unit

ISSUE DATE: 08/96

REVISION DATE(S): 05/98, 08/00, 10/01, 02/02, 02/03, 01/05, 06/07, 06/10, 04/13

Department Approval: 12/16
Division of Psychiatry Approval: 06/17
Pharmacy and Therapeutics Approval: n/a
Medical Executive Committee Approval: 07/17

Professional Affairs Committee Approval:

Board of Directors Approval:

A. PURPOSE:

1. To define appropriate methods for admitting a patient to an inpatient psychiatric unit.

B. **POLICY**:

1. When a patient is in need of inpatient treatment, the program staff and attending physician will arrange the admission.

C. PROCEDURE:

- Who may perform/responsible: Clinical and Nursing Staff
 - a. The treatment team, to include the Clinical Coordinator, Operations Manager and **Registered Nurse** (RN) whenever possible, meets to triage the patient and determine the need for inpatient admission.
 - b. The clinical staff contacts the attending psychiatrist to inform him/her of the current situation and the staff's assessment of the patient and recommendations for admission.
 - c. If the attending psychiatrist concurs that admission is necessary, s/he makes the recommendation as to whether a direct admission or Emergency Department (ED) admission must occur. If a direct admission is recommended, the attending psychiatrist, or designee contacts the on-call physician to make the recommendation and communicate information obtained in the clinical assessment. If an ED admission is recommended, the clinical staff contacts the psychiatric liaison to inform them regarding the potential admission. Once the patient is medically cleared in the ED, they may be transferred to the crisis stabilization unit for evaluation and treatment or admitted to inpatient behavioral health unit.
 - d. If the patient refuses hospitalization, the attending program psychiatrist makes a determination as to whether a hold is necessary.
 - e. The staff will be responsible for arranging for transport of the patient and obtaining consents from the patient/conservator, as needed. Depending on level of risk, a patient may need to be accompanied by staff on program van or be transported via ambulance.
 - f. Staff will use the Situation, Background, Assessment, Recommendation (SBAR) process to conduct hand off communication with the intake coordinator, psychiatric liaison, shift Supervisor, MD, police department, or ambulance.
 - g. The program staff will notify the patient's family or significant others of the transfer, in accordance with the patient's wishes. If appropriate, the patient's insurance reviewer is contacted and informed regarding the inpatient admission.
 - h. Patient information/records will be sent at the time of transfer. These records will include diagnosis, pertinent financial/administrative information, current medical findings, current medications and a brief summary of the course of treatment. Program nurse and clinical staff will ensure accuracy of medication reconciliation and hand off communication.



Outpatient Behavioral Health Services

SUBJECT:

Age Appropriate Care

ISSUE DATE:

08/96

REVISION DATE(S): 05/98, 08/00, 10/01, 02/02, 02/03, 01/05, 06/07, 06/10, 04/13

Department Approval:

12/16

Division of Psychiatry Approval:

06/17

Pharmacy and Therapeutics Approval:

n/a

Medical Executive Committee Approval:

07/17

Professional Affairs Committee Approval:

Board of Directors Approval:

A.

To provide guidelines to meet the age specific care needs of the patient and educate their caregiver and/or family.

B. **POLICY**

OPBHS serves adults 18 and older. Efforts must be made to individualize the program to meet the specific needs of individuals and address age-related issues. Older adults may attend specialized groups to address issues related to their specific age group, such as aging and grief and loss issues. Likewise, young adults may be scheduled for groups with individuals of similar age to address issues that may arise for their age group, such as academic or job-related concerns. All employees shall demonstrate the skills and knowledge required to provide care appropriate to the age of the patients served. Caregiver/family shall be involved in treatment to meet the age specific needs of the patient.

C. **PROCEDURE**

- Who may perform/responsible: Outpatient Behavioral Health Services BHOS (OPBHS) staff
 - Educational information including the principles of growth and development will be provided during orientation.
 - b. The knowledge and skills necessary for providing age specific care will be reviewed annually.
 - C. Knowledge, skill base, and ability to provide care appropriate to the age of the patient will be evaluated during orientation and at each annual performance review.
 - d. Employees will include family/caregiver, as appropriate, in meeting age specific needs of the patient.
 - Treatment approaches will be modified to meet the age specific physiological. e. psychological, educational and social needs of the patient.
 - f. Medications will be prescribed in age appropriate medication dosages; therapeutic ranges can be obtained from the pharmacy and laboratory department as needed.

DELETE: Department guideline, does not need to be a policy.

SUBJECT:

Communications

ISSUE DATE:

08/96

REVISION DATE(S): 05/98, 08/00, 10/01, 02/02, 02/03, 01/05, 06/07, 06/10, 04/13

Department Approval:

12/16

Division of Psychiatry Approval:

06/17

Pharmacy and Therapeutics Approval

n/a

Medical Executive Committee Approval:

07/17

Professional Affairs Committee Approval:

Board of Directors Approval:

PURPOSE

1. To define the policy regarding communication throughout the Program and with Tri-City Healthcare District (TCHD)Medical Center.

B. POLICY

1. All program staff have a responsibility to decrease barriers to communication and to make an effort to communicate effectively. Confidentiality of both verbal and written communication must be maintained at all times. Each staff member is expected to know the appropriate lines of reporting indicated in their job description and in specific policies and procedures. All staff act as role models in helping patients to communicate effectively.

C. PROCEDURE

Who may perform/responsible: Outpatient Behavioral Health Services (OPBHS) Staff

- Meetings are held weekly to facilitate interdisciplinary communication. These include but are not limited to: staff meetings, clinical problem solving meetings and treatment team meetings.
- A Patient Review meeting will take place each morning to review the previous day's
 events, review new admissions, issues related to patient care, and to discuss the
 schedule of the day.
- 3.a. The Operations Manager is also involved in TCHDTri-City Medical Center meetings at the direction of the Director of Behavioral Health, which may include Leadership Meetings, Leadership College, Manager's meetings, and Behavior Health Unit (BHU) meetings. Relevant information gained at these meetings is shared with program staff.



Delete: Department guideline, does not need to be a policy.

SUBJECT:

Solicitation of Patients / Referrals to Self

ISSUE DATE:

08/96

REVISION DATE(S): 05/98, 08/00, 10/01, 02/02, 02/03, 01/05, 06/07, 06/10, 04/13

Department Approval:

12/16

Division of Psychiatry Approval:

06/17

Pharmacy and Therapeutics Approval:

n/a

Medical Executive Committee Approval:

07/17

Professional Affairs Committee Approval:

Board of Directors Approval:

PURPOSE:

To specify parameters with respect to the solicitation of patients or referrals to self.

B.

- Who may perform/responsible: Outpatient-Behavioral Health Services (OPBHS) Clinical Staff
- Tri-City Healthcare District (TCHD)Medical Center employees and contracted employees will not refer patients, directly or indirectly, to their private practices.
- Tri-City Medical CenterTCHD employees and contracted employees will not, directly or indirectly, approach, solicit or suggest to any patient (or patient's representative) that the patient should or must-see such employee on any basis outside the program(s) for additional care or therapy, with the exception of those patients who were seen in the therapist's private practice prior to the patient being admitted to the program. In such a case, referrals back to the therapist's private practice is are acceptable, if deemed clinically appropriate.
- If additional treatment is needed, as determined by the treatment team a list of at least three qualified therapists will be given to the patient for the patient's selection.
- 5.1. An exception to the above is when a patient expresses an interest in continuing to see the program psychiatrist after discharge from program. In that case, it would be acceptable for the patient to continue to be treated by the program psychiatrist in their private practice.



SUBJECT:

Substance Abuse

ISSUE DATE:

08/96

REVISION DATE(S): 05/98, 08/00, 10/01, 02/02, 02/03, 01/05, 06/07, 06/10, 04/13

Department Approval:

12/16

Division of Psychiatry Approval:

06/17

Pharmacy and Therapeutics Approval:

n/a

Medical Executive Committee Approval:

07/17

Professional Affairs Committee Approval

Board of Directors Approval:

To identify steps to address use of non-prescribed drugs or alcohol in Outpatient Behavioral Health Services.

B.A. **POLICY:**

- Patients with secondary-comorbid substance abuse problems or dual diagnosis may be treated in the ProgramOPBHS if they agree to abide byadhere to ProgramOPBHS rules-guidelines and if they agree to accept treatment for their substance useabuse problem.
- 2. Patients are not permitted to attend the ProgramOPBHS under the influence of alcohol. marijuana or street-illicit drugs or to bring those substances to the ProgramOPBHS. Substance abuse is also defined as "taking excessive amounts of misuse of prescribed medications".
 - An individual under influence can include individuals that use alcohol, marijuana, illicit drugs or misuse prescribed medications the day they are in the program or the night before.
 - Behaviors that may indicate an individual is under the influence include, someone b. behaving differently than usual, erratic, with an altered state of consciousness. unpredictable behavior, agitation, excessive sedation, slurred speech, dilated eyes, impaired gait, etc.
- 3. If the patient's substance abuse-use problem becomes so severe that it endangers the patient's safety, interferes with psychiatric treatment, or prevents the patient from benefiting from treatment, a referral to a higher level of care or a substance abuse program may be made.

€.B. PROCEDURE:

- 1. Who may perform/responsible: OPBHS Clinical and Nursing Staff
- 1.2. If substance abuse is detected by programOPBHS staff during programOPBHS time, the patient will be dismissed for the day. The patient's physician/Allied Health Professional (AHP) will be immediately notified.
- 3. If the patient may be medically endangered by his substance abuse, the physician/AHP will be notified before the patient is dismissed in order to determine the best approach to take and to assess the need for immediate medical treatment.
- 2.4. With collaboration with physicians/Allied Health Professionals, OPBHS staff will determine a safe plan to transport the individual home and to ensure that the individual does not drive under the influence.
- At the time of dismissal, the patient will be reminded that he/she must meet with the Therapist or 3.5. treatment team before he/she may continue in the ProgramOPBHS. If the patient does not call back within 24 hours, the Therapist will contact the patient to schedule the meeting. The meeting will include consideration of the patient's possible need for substance abuse treatment,

- within or independent of the ProgramOPBHS.
- 4.6. If the individual continues in treatment, a contract for continuing participation in the Dual Diagnosis component of the program will-may be developed. The contract may address various issues, such as substance abuse abstinence, participation in dual diagnosis groups, 12-step meeting attendance, avoidance of high risk places or things, etc.
- 5.7. Repeated violations of ProgramOPBHS rules concerning substance abuse may result in the patient's discharge from the ProgramOPBHS.
- 6-8. The incident is documented in the patient's record along with a description of the action taken.
- **7.9.** Patients are referred to a higher level of care or substance use treatment if they are determined to meet one or more exclusionary criteria, which include:
 - Lack of interest in being clean or sober and refusal to reduce substance use
 - b. Daily excessive drinking or signs of withdrawal and increased tolerance
 - c. More than one occasion of coming to programOPBHS under the influence
 - d. Multiple relapses and refusal to take steps to improve chance of success
 - e. Inability to reduce use
 - f. Multiple episodes of dishonesty regarding use
 - g. High risk of suicide, violence, medical issues, homicide, or severe exacerbation of symptoms associated with use.
 - h. Extent of prescription use leads to high risk of self harm
 - i. Refusal to communicate with other prescribing physicians/AHPsMDs, or primary care physician (PCP), or family/caregivers combined with severe risk of self harm
 - j. Continued use of multiple pharmacies, **Emergency Departments** (EDs), and physicians/**AHPs** and refusal to change this high risk behavior
 - k. Poses a risk to milieu by influencing other patient to use substances
 - I. The team, including the physician, determines that patient has a current primary issue with substance use and can benefit from substance use treatment.



SUBJECT:

Suicide Assessment

ISSUE DATE:

08/96

REVISION DATE(S): 05/98, 08/00, 10/01, 02/02, 02/03, 01/05, 06/07, 06/10, 04/13

Department Approval:

12/16

Division of Psychiatry Approval:

06/17

Pharmacy and Therapeutics Approval:

n/a

Medical Executive Committee Approval:

07/17

Professional Affairs Committee Approval:

Board of Directors Approval:

A.

To define the course of action necessary when a patient expresses suicidal ideation.

B.

Acutely suicidal patients are not appropriate for Outpatient Behavioral Health Services (OPBHS) and need to be evaluated for inpatient treatment. If a patient is admitted for inpatient care, programOPBHS staff will follow the patient's progress and assist in assessing the patient's readiness to return to the ProgramOPBHS. Patients reporting suicidal ideation will be assessed for level of risk and appropriate interventions will be conducted accordingly.

C. **PROCEDURE:**

- -Who may perform/responsible: OPBHS Clinical Staff.
- 1.2. All new patients will undergo an evidence-based suicide risk assessment, such as the Columbia-Suicide Severity Rating Scale (C-SSRS). The assessment is -atcompleted at intake that is completed by the admitting RNClinical staff.
- If a patient is assessed to be at moderate or high risk for suicide, then the RN-staff notifies the 2.3. physician/Allied Health Professional (AHP) and therapist in order to evaluate appropriate level of care needed for the patient.
- If MD-physician/AHP determines that the patient can safely remain in programOPBHS, RN 3.4. willstaff will provide the patient with information on how to access emergency crisis services and will develop a safety plan.
- 4.5. The therapist will establish a treatment goal specifically addressing safety for those patients that score moderate to high on the suicide assessment.
- 5.6. If, during the course of treatment, the programOPBHS staff member becomes aware of a patient's suicidal intentions or actions, he/she becomes responsible for initiating a course of action. That person, or designee, must take necessary precautions to ensure patient's safety.
- 7. Assessment will be immediately initiated to determine the risk of the suicidal intent or action.
 - (Some of the factors to consider are: whether the patient has a specific plan to make an attempt, whether the patient is now experiencing circumstances that would enhance the likelihood of the attempt, etc.).
- 7.8. The staff member who discovers the situation will initiate a plan of action after informing the physician, Clinical Coordinator, and the Operations Manager.
- 8.9. An action plan is initiated based on the assessment of acuity.
 - If a suicide attempt has already been made, the patient is to be transferred immediately to Tri-City Healthcare District's (TCHD) Medical Center emergency room by ambulance. A staff member will be designated to notify the patient's physician/AHP and family member or significant other.

- b. If a suicide attempt has not been made, but the threat is considered to be imminent, the patient's physician/AHP is to be contacted immediately to give direction concerning the patient's disposition. If the patient's attending physician/AHP is not available, the Medical Director will be contacted.
- c. Patients that are identified at risk will be closely monitored until they are transported safely for inpatient treatment.
- **d.** Patients that are on close watch will be asked to voluntary give staff their belongings in case they possess any contraband items and to protect their safety.
- d.e. If the threat of suicide is determined not to be imminent, the staff member will notify other staff and the Operations Managertreatment team will be notified to heighten awareness to possible future suicidal intent-risk and also to plan further treatment interventions. A written safety plan will be developed by the patient and the therapist to help identify warning signs, coping strategies, and emergency resources. contract to notify staff before acting on any impulse may be signed by both patient and staff and placed in the chart. A written contract is to be used as a therapeutic intervention rather than an effort to protect the program.written safety plan will be completed to help patients identify resources and remain safe. If appropriate, the patient's family/support system/Board and Care Manager should be contacted to monitor for safety.
- 9. Document in the patient's chart-medical record the patient's statements and actions, the assessment process, the disposition of the patient and staff interventions. If the patient is to remain in programOPBHS, the therapist may initiate a written contract safety plan to include emergency crisis numbers and address steps that can be taken if the patient felt unsafe.
- 10. The patient's Therapist will discuss all verbalizations of suicidal ideation with the patient's attending psychiatrist and the treatment team in order to develop appropriate treatment interventions.
- 11. the The Program OPBHS staff will contact the inpatient treatment team, should the patient be hospitalized, to insure continuity of care and to conduct hand-off communication.

D. RELATED RESOURCES DOCUMENT(S):

1. Outpatient Behavioral Health: Psychiatric Emergencies

E. REFERENCES:

- 1. The Columbia Suicide Severity Rating Scale (C-SSRS) Supporting Evidence (2017)
- 2. The Joint Commission Source Newsletter (2016)
- 12.3. The Joint Commission National Patient Safety Goals (2017)



OUTPATIENT INFUSION CENTER - OCEANSIDE POLICY MANUAL

ISSUE DATE:

032/13

SUBJECT: ADVERSE REACTION

(MEDICATION EVENT)

REVISION DATE: 03/13

Department Approval:	06/16
MEDICAL/DEPARTMENT:	3/13
DIRECTOR APPROVAL:	3/13
Division of Oncology Approval:	03/17
Pharmacy and Therapeutics Approval:	07/17
Medical Executive Committee Approval:	∘ 08/17
Professional Affairs Committee Approval:	
Board of Directors Approval:	03/13

A. **PURPOSE**:

1. Patient medication events including adverse reactions must be reported appropriately and acted upon in a timely manner. This policy defines the procedure to be followed by the OPOutpatient Infusion Center (Center) when a medication error/reaction/event occurs.

B. **POLICY:**

- 1. The Center will adhere to the hospitals pharmacy policy(s) related to medication events/adverse reaction and utilize appropriate hospital reporting forms.
- 2. All adverse drug reactions/medication events will be reported immediately and will include notification of the practitioner who ordered the drug, as well as the patient/family.
- 3. Appropriate documentation will be recorded in the medical record.
- 4. The pharmacy will report serious adverse drug reactions to the Food and Drug Administration as required.

C. PROCEDURE:

- 1. The nurse shall:
 - a. Notify the attending and/or onsite physician of the medication event/reaction
 - a.b. If the interventions ordered by the attending and/or onsite provider fails when patient is having anaphylactic symptoms, the nurse or designee will call 911 for emergency services.
 - b.c. Notify the patient/family of the incident.
 - e.d. Complete the appropriate form to the pharmacy immediately.
 - **e.** Document the event/reaction, the orders received, and the effect/condition of the patient in the patient's medical record.

D. RELATED DOCUMENT(S):

d-1. Administrative Policy: Incident Report—Quality Review Report (QRR) RL Solutions 396

Tri-City Me	dical Center	Distribu	ution: Outpatient Infusion Center
PROCEDURE:	CENTRAL VENOUS ACCESS DE	VICES,	ADULTS
Purpese:	To outline the nursing responsibility A. Insertion B. Assessment C. Maintenance	' in:	DELETE – follows Patient Care Services Procedure: Central Venous Access Devices, Adults
	D. Documentation E. Flushing F. Blood draws G. Dressing changes H. Accessing or de accessing implementation	lantable	venous access ports
		al lines (Peripherally Inserted Central Venous Catheter
Supportive Data:	See Infection Control Manual Blood	lborne F	athogen Exposure Control Plan (I.C.10).
Equipment:	Refer to Appendix A for details.		

ONLY REGISTERED NURSES (RNs) MAY ACCESS CENTRAL LINES

A. <u>Insertion</u>

- 1. Assemble supplies (See Attachment B for procedure lists)
- Propose optimal catheter site to physician, with Subclavian Vein as the preferred site for nontunneled catheters.
- 3. Ensure the physician has performed chlorhexidine skin antisepsis
- 4. Provide maximal barrier precautions for inserting physician and assisting personnel (i.e., cap, mask, sterile gown, sterile gloves and full body sterile drape)
- 5. Ensure "time-out" is performed per Patient Care Services (PCS) Universal Protocol procedure
- The Registered Nurse (RN)/healthcare provider (HCP) shall ensure sterility of the field is maintained throughout the procedure.
- 7. Verify an X-ray is ordered and completed after placement on newly inserted central venous catheters.
- 8. Ensure Central Line Insertion Procedural Checklist is completed (see Attachment A)

B. ASSESSMENT

- 1. Monitor intravenous sites every 2 hours and PRN. Document each shift on the Assessment Ongoing PowerForm Central IV section.
- 2. Central venous catheters are assessed daily to determine continued need and are removed when no longer needed.
 - a. The primary RN is responsible for ensuring the unit secretary places a "Physician Daily Assessment of Central Line Necessity "sticker on a Physician Order sheet daily.
 - b. When a unit secretary is not available, the Shift Supervisor shall ensure the "Physician Daily Assessment of Central Line Necessity" sticker is placed on a Physician Order sheet.
 - Does not apply to long term catheters (Groshong, Tunneled Catheter, Medi-Port, and Vas Cath)

C. MAINTENANCE

- 1. Use all new tubing after new PICC/central line placement.
- Label IV tubing and/or neutral displacement connector (Microclave) with change date sticker indicating date tubing is to be changed using numerical day and month.
- Change tubing and any attached devices (e.g. extension tubing, neutral displacement connector) every 4 days.

Department Review	Division of Oncology	Pharmacy and Therapeutics	Medical Executive Committee	Professional Affairs Committee	Board of Directors
03/13, 01/17	03/17	07/17	03/13, 08/17	03/13	03/13

- 4. Use an infusion pump for all infusions.
 - DO NOT ALLOW INFUSIONS TO RUN DRY.
- 5. Clamp tubing distally if air enters infusion tubing; aspirate fluid and air with a syringe from Y port. Never purge infusion line into patient.
- 6. Maintain keep open rates at 20 mL per hour.
- Continuous infusions may be connected hub to hub. Microclave device is only required for intermittent access.
- 8. SwabCap Unused central line ports will have a SwabCap placed on the end of the neutral displacement connector (Microclave).
 - a. Apply the SwabCap to the end of the neutral displacement connector (Microclave) by epening the packaging of the SwabCap and twist into the end of the neutral displacement connector (Microclave).
 - b. To access a central line that has a SwabCap, remove the SwabCap from the neutral displacement connector (Microclave) and access central line port. No initial cleaning of the neutral displacement connector (Microclave) is needed after SwabCap is removed.
 - c. Do not reuse the SwabCap, a new one should be used each time it is removed, every 8 hours with routine IV flushing and PRN.
- 9. Outpatient Infusion Center may replace Chlorhexadine with Alchohol/Betadine skin prep for dressing changes and Implanted Port access.

D. DOCUMENTATION

- 1. Document and complete all sections of the Assessment Ongoing PowerForm in the Central IV section.
- 2. Document flushing on the Medication Administration Record (MAR)
- 3. Record teaching on the Patient Education PowerForm.

E. FLUSHING

- Obtain a physician's order prior to accessing any central venous catheter if the patient is admitted with a pre-existing line and a diagnosis of sepsis or suspicion of line sepsis.
- 2. Always flush and check patency with a 10 mL size syringe due to the greater amount of pressure per square inch exerted with smaller syringes. Once patency has been established with a 10 mL normal saline flush, the use of a smaller syringe to administer medications is acceptable.
- Flush with minimum of 10 mL normal saline:
 - Before and after medication administration,
 - b. After IV fluids or TPN discontinued
 - c. For maintenance
 - Before and after blood draws
 - e. -- After blood backs up in the tubing
- Flush unused ports with each use and as indicated in Catheter Specific Flushes table (see Attachment C)
- Heparin flushes require a physicians order. Refer to Central Venous Access Device Flushes
 Pre-Printed Order.
- 6. Flush ports with heparin for patients discharged with a central line to ensure patency for home care or other facility use (see Attachment C).

7. PROCEDURE:

- a. Identify type of catheter
- b. Check for Chloraprep (2% chlorhexidine gluconate/70% isopropyl alcohol), Heparin, Betadine, and alcohol allergies.
- Assemble supplies (See Attachment B for procedure-lists)
- d. Explain procedure to patient.
- e. Perform hand hygiene and don clean non-sterile gloves.
- f. Remove SwabCap from the neutral displacement-connector (Microclave) if used.
- i.- If a SwabCap is not present on injection port, cleanse neutral displacement connector thoroughly using 3 alcohol wipes or chlorhexidine swab.

- g. Briskly flush catheter with normal saline and follow with catheter specific flush (See Attachment C).
- Always wipe the neutral displacement connector with an alcohol wipe immediately before and after each syringe insertion to remove bacteria and prevent blood from accumulating.
- i. Repeat flush procedure for each catheter lumen.

BLOOD SPECIMEN COLLECTION FROM VENOUS ACCESS DEVICES

- 1. Peripheral blood is preferable for coagulation studies. A physician's order is required if a line will be used to obtain blood for coagulation studies when the line has heparin infusing or if heparin was used as a routine flush.
- Maintain a closed-system by drawing blood directly from the neutral displacement connector when possible; except when drawing blood-cultures.
 - a. If the neutral displacement connector is removed for a blood draw, aseptic technique (with sterile gloves, mask and sterile field) must be used.
- 3. On Acute Care Services (ACS) and Telemetry, a phlebotomist shall place plastic bags labeled with the patient's identifiers in the "Pending Labs" box on each unit prior to the morning blood draws.
- 4. Nursing shall review their orders for morning draws and complete the blood draws.
- 5. Once the blood draws are completed, nursing shall return the labeled specimen collection tubes to the patient's plastic specimen bag and place the specimen bag in the "Lab Test Pick-Up" box for phlebotomy to pick up.
- 6. Phlebotomy shall contact nursing on ACS and Telemetry if additional blood draws are required after the morning draw.
 - a. Nursing may complete the blood draws without a phlebotomist being present.
 - A phlebotomist must be present for blood cultures and blood bank draws.

7. PROCEDURE:

- Remove patient identified plastic bag with specimen collection supplies from the Pending Lab box on Acute Care Services and Telemetry.
 - i. Do not take plastic specimen bag into isolation rooms.
- b. Verify patient by ensuring two patient identifiers match the specimen collection labels
- c. Perform hand hygiene
- d. Assemble supplies (See Attachment B for procedure lists).
- e. Explain procedure to patient.
- f. Position patient, supine is the preferred position.
- g. Turn off any continuous infusions and disconnect as needed.
- h. Ensure all clamps are open.
- i. Perform hand hygiene and don clean non-sterile gloves.
- j. Remove SwabCap from the neutral displacement connector (Microclave) if used.
 - i. If a SwabCap is not present on injection port, use alcohol pad to vigorously cleanse the neutral displacement connector or injection port and the area where valve connects to end of catheter. Repeat three times using a new alcohol pad each time. Allow injection port to dry, do not fan or blow on port to speed drying.
- k. Use alcohol pad to vigorously cleanse the neutral displacement connector or injection port and the area where valve connects to end of catheter. Repeat three times using a new alcohol pad each time. Allow injection port to dry, do not fan or blow on port to speed drying.
- Flush with 10 mL normal saline; wait 2 minutes.
- m. Draw off-and-discard 5 mL of blood. If drawing specimens for blood cultures or coagulation studies are to be obtained or the line-has TPN infusing draw off and discard 10 mL of blood.
 - Prior to drawing blood cultures, disconnect tubing or neutral displacement connector, attach 10 mL syringe to hub, and collect discard blood.

To draw blood culture, follow asoptic technique, use a new 10 mL syringe, and collect blood directly at the hub. Reconnect tubing or replace with a new neutral displacement connector. Clean the neutral displacement connector with an alcohol wipe immediately before and after each access to remove bacteria and prevent blood from accumulating. Allow to dry, do not fan or blow on site to speed drying. For Direct Transfer Method Insert safety vacutainer blood collection device into the neutral displacement connector using a slight clockwise turning motion. Insert blood specimen collection tube and activate vacuum by fully engaging the blood tube. - On ACS and Telemetry, insert blood specimen collection tube in the appropriate numbered draw order i.e. 1, 2, etc). Remove and insert new vacuum tubes as needed. For Indirect Transfer Method Attach new 10 mL luer lock syringe(s) to collect blood as needed. A safety transfer device must be used to fill the vacuum tube from a syringe. Remove device or syringe and wipe away blood residual. Flush as indicated in Catheter Specific Flushes table (see Attachment C) and reconnect to infusions. Re-clamp lines as appropriate. Remove gloves and perform hand hygiene Don clean gloves Document your Cerner logon, date and time of lab draw on the specimen label(s) Place label(s) on specimen collection tube(s) at patient's bedside. On ACS and telemetry, ensure the color written on the patient label(s) matches the color of the specimen collection tube(s).

Place labeled specimen collection tube(s) in the patient's specimen collection bag on

G. DRESSING CHANGES

- Transparent dressings with Biopatch disk shall be changed every 7 days.
- 2. Gauze dressings (including transparent dressings with gauze underneath) shall be changed every two days.

A phlebotomist will transport the specimen(s) to the lab.

- Dressings shall be changed as needed if they become loose, soiled, or moist.
- 4. Access needles for implanted ports shall be changed every 7 days.
- 5. Central neutral displacement connector (Microclave) shall be changed every 4 days.

Place specimen collection bag in the "Lab Test Pick Up" box.

6. For newly inserted PICCs with a gauze dressing, the original dressing must be changed one day after insertion.

7. PROCEDURE:

- a. Obtain central line dressing change kit from supply Pyxis.
- b. Explain-procedure to patient.

ACS and Telemetry units.

- S. Use Standard Precautions during dressing change (Refer to Infection Control Policy IC.5 Standard and Transmission Based Precautions).
- d. Avoid talking over site and have the patient turn away from the site to prevent contamination.
- e. Perform hand hygiene, don clean non-sterile gloves, and remove the dressing and discard.
- f. Inspect the site for:
 - Signs of infection i.e. redness, or purulent drainage.
 - ii. Ensure the securement device and/or sutures are intact
 - iii. Ensure the catheter is not kinked, leaking, or otherwise compromised.

Remove non-sterile-gloves and perform hand hygiene. Open sterile supplies and don sterile gloves and sterile mask. Perform hand hygiene and don sterile gloves Apply Chloraprep using a gentle back-and-forth motion for 30 seconds to cleanse exit site and allow site to air-dry for at least 30 seconds. Cleanse catheter tubing from exit site to distal end. Allow antiseptic to air dry (do not blow on or fan site) before redressing. Replace securement device if needed per manufacturer's guidelines. Position tubing in a loop away from the insertion site. Transparent Dressing with Biopatch Place Biopatch disk around catheter with blue side up and white foam side next to skin at exit site. To ensure easy removal, place Biopatch disk with the catheter resting on or near the radial slit. The edges of the slit must touch the skin to ensure efficacy. Center transparent dressing over exit site and the Biopatch disk. Write date of dressing change and your initials legibly with a permanent black marker directly on the transparent dressing, allowing time for the ink to dry. Implanted Venous Access Devices/Vita Ports/Medi-Ports Place folded 2x2 gauze under wings only if wings are not flush with skin. Gauze should be placed under wings in such a way as to allow visibility of

H. ACCESSING OR DE-ACCESSING IMPLANTED VENOUS PORTS

insertion point.

1.— ACCESSING PROCEDURE:

- Obtain physician's order to use implanted device.
- b. Assemble supplies (See Attachment B for procedure lists) and use safety needles.

marker directly on the dressing, allowing time for the ink to dry.

Write date of dressing change and your initials legibly with a permanent black

- c. Explain procedure to patient.
- d. Check for Chloraprep, Heparin, Betadine, and alcohol allergies.

Secure wings with sterile steri-strips.
Use transparent dressing to cover site.

- e. Use Standard Precautions while accessing implanted venous ports (Refer to Infection Control Policy IC.5 Standard and Transmission Based Precautions)
- f. Avoid talking over site and have the patient turn away from the site to prevent contamination.
- g. Assemble equipment on sterile field.
- n. Perform hand hygiene and don sterile gloves and using aseptic technique waste 5mL normal saline from 10mL pre-filled syringe then prime the non-coring needle and extension tubing (with neutral displacement connector attached). Leave the syringe attached.
- i. Using Chloraprep, cleanse area over implanted port thoroughly with a gentle back-and-forth motion for 30 seconds. Allow to air-dry for 30 seconds. Do not fan or blow on site to speed drying. Use Betadine if patient is allergic to Chloraprep or alcohol.
 - Locate port septum by palpation and triangulate port between the thumb and first two fingers of non-dominant hand.
 - ii. Aim for the center of the port and insert the needle, perpendicular to port septum. Advance needle through skin and septum until it reaches the bottom of the reservoir.
- j. Do not begin injection or infusion until proper needle placement is confirmed by aspirating blood. Confirm placement by:
 - i. Aspirating 5-mL of blood using the 10 mL syringe attached to the extension tubing.
 - ii. Waste 5mL aspirant.
 - iii. Flush with 10mL normal saline.

Apply dressing per "Dressing Change" (section F) procedure. Date and initial dressing. After procedure, flush with 10 mL normal saline and follow with catheter specific flush (see Attachment C) or connect to IV infusion as ordered. If implanted port must be accessed multiple times for PRN or intermittent medication regime, obtain a physician's order for KVO solution. If KVO order is unobtainable and port must be accessed multiple times perform the following: -Withdraw 5 mL from accessed implanted port and discard (removes heparin) Flush port with 10 mL of normal saline after heparin has been removed Administer medication or IV via port When port is no longer needed, flush with 10 mL of normal saline and heparinize port per flush table. (Attachment C) Access needle for implanted ports shall be changed every 7 days. DE-ACCESSING PROCEDURE: Check for blood return prior to flushing port with a 10 mL pre filled normal saline syringe. Flush port with 10 mL normal saline ALWAYS flush port with specific flush prior to de-accessing (See Attachment C). Perform hand hygiene and don clean non-sterile gloves to remove transparent dressing. Lift from the edge and stretch film laterally for easier removal. Remove securement device if applicable. Inspect the site for signs of infection (redness, pain, swelling and/or purulent drainage. Cleanse exit site using Chloraprep, the preferred antiseptic, or Betadine if patient is allergic to Chloraprep or alcohol. To remove the safety needle device, place fingers on the base to stabilize. With other hand, place finger on the tip of the safety arm. Lift the safety arm straight back as needle is safely removed. A click will be heard indicating the tip of the needle is fully encased. Discard needle in a sharps container. Apply small band-aid. REMOVAL OF NON-TUNNELED CENTRAL LINES (PICCs, Multi-Lumen, Vas Cath) PROCEDURE: Verify physician order to discontinue line. Assemble supplies (See Attachment B for procedure lists) Explain procedure to patient. Place absorbent pad under catheter site. Have patient lay flat or have head of bed no more than 30 degrees if possible. Use Standard Precautions for removal of non-tunneled central lines (Refer to Infection Control Policy IC.5 Standard and Transmission Based Procautions) Open the suture removal kit. Perform hand hygiene and don clean non-sterile gloves to remove the dressing and discard. Check-site for signs of infection. If there are signs of infection, send the catheter tip to the laboratory for culture and sensitivity testing, per physician's order. Remove securement device if applicable. Cleanse exit site with Chloraprop with a back and forth motion for 30 seconds. Use

Betadine if patient is allergic to Chloraprep or alcohol.

his/her breath and bear down, place the bed as flat as possible. For PICCs, have patient keep her/his arm straight.

so as not to cut catheter or patient's skin.

Carefully remove sutures by grasping one-at-a-time-with forceps held by the non-

dominant hand. Use the dominant hand to clip suture at a spot close the skin. Take care

Instruct patient to perform Valsalva maneuver during removal. If patient is unable to hold

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- n. With 4x4 pad in non-dominant hand, grasp catheter with dominant hand and gently pull the catheter to remove. As catheter is coming out, place 4x4 over insertion site.
- Once removed, apply pressure with sterile 4x4 gauze to the insertion site for 5-10 minutes or until bleeding has ceased.
- Apply new sterile folded 4x4, secure with large transparent dressing, and instruct patient to leave dressing on for 24 hours.
- q. Instruct patient to report shortness of breath, hematoma, or bleeding.

ACCESSING THE DOUBLE LUMEN SUBCLAVIAN/INTERNAL JUGULAR VASCATH/PERMCATH

1. These Catheters Contain Large Doses of Heparin. HEPARIN MUST BE ASPIRATED BEFORE USE.

2. ACCESSING PROCEDURE:

- a. Obtain a physician's order to access ONLY the venous port (blue port) r.
- Explain procedure to patient.
- c. Assemble supplies (See Attachment B for procedure lists)
- d. Use Standard Precautions while accessing the double lumen subclavian/internal jugular vascath/permeath (Refer to Infection Control Policy IC.5 Standard and Transmission Based Precautions)
- Expose limb with the vas cath/permacath to prevent the patient from contaminating the ports with linens or gown.
- f. Place absorbent pad under the limb to protect clothing and linen. Place sterile drape over Chux and have patient center limb on the drape.
- g. Perform hand hygiene and don sterile gloves.
- Ensure venous line is clamped before accessing.
- i. Saturate venous port thoroughly with Betadine and let stand for 5 minutes.
- j. Attach 10 mL syringe using aseptic technique
- k. Unclamp and aspirate 5 mL (7 mL if drawing a PT or PTT).
- Clamp line and discard syringe.
- m. Attach 10 mL syringe containing 10 mL of normal saline.
- n. Unclamp venous port and instill 10 mL of normal saline.
- Clamp venous port and remove syringe.
 - Venous line may now be accessed for IV fluids/IV medication administration.
 - 1) If a blood draw is needed, follow item E of this procedure "Blood Specimen Collection from Venous Access Devices."

3. **DE-ACCESSING:**

- Flush venous port with 10 mL of normal saline after medication administration, after discontinuing IV fluids or after completion of blood draw.
- b. Heparinize Port (see Attachment C for dosage) and label with a "Caution High Dose Heparin" sticker.

K. FORMS

- Central Line Insertion Procedural Checklist
- 2. Central Line Supply List
- Central Line Catheter Specific Flushes

REFERENCES:

- San Diego Dialysis Center. (2204). Fmc homodialysis procedure manual.
- Infusion Nursing Standards of Practice. (2006)
- 3. Bard. (n.d.) Long term polyurethane hemodialysis/apheresis catheters. Bard nursing procedure manual

Attachment A

Central Line Insertion Procedural Checklist

Rationale: Evaluation of procedural practice during Central Venous Catheter insertion. Achieve compliance with CDPH mandates for public reporting under SB739.

Date:			
Patient Name:	MRN:	Room	Number:
Procedure performed in:	-⊟- Interventional Radiology -⊟-	Other - Specify	(i.e. NICU ICU, ED, OR)
	-⊟ Interventional Physician ⊟- - Other specify		Other Medical Staff
Checklist completed by:	-⊟Inserter	Observer	
Indication for Central Line — New access	: □ Replace malfunctioning line	— □ Suspect central lin	e infection
Line changed over guide v	vire?	─────────────────────────────────────	-
	prior to central line insertion: ncludes the use of alcohol-based !		
Sterile Gown: Large sterile drape (full l Sterile Gloves: Cap:	body): w the same precautions?	—) → →
Chlorhexidine-gluconate	(Chloraprep)		
Alcohol		—⊟ Yes ⊟ No)
Was skin agent completely *30 seconds for dry site **2 minutes for moist site	dry at the time of first puncture (especially femoral)	e?-⊟Yes⊟No	•
	pper extremity ☐ PICC Lower (ian ☐ Femoral		
⊟—Tun ⊟—Dial	C	eter tunneled	•
Number of lumens			
Was antiseptic ointment a	pplied to the site?	ith date and time?	─────────────────────────────────────

Please return completed form to the Manager and forward to Infection Prevention and Control. Thank you

Outpatient Infusion Center Manual Central Venous Access Devices Page 9 of 11 Attachment-A

Central Line Insertion Procedural Checklist

Rationale: Evaluation of procedural practice during Central Venous Catheter insertion in the Intensive Care Unit.



Please return completed form to Clinical Manager.

Thank you

	Central Line Supply lists Attachment B
Insertion	1. Central Line insertion kit
	2. Caps for assistant and physician
	3. Full face shield for assistant
	4. Mask with face shield for physician
	5. Sterile gloves for assistant and physician
	6. Sterile gown for physician
	7. Full body sterile drape
	8. Alcohol gel hand hygiene solution
Flushes	1. Non-sterile gloves. Mask if flushing a vas cath/permacath.
	2. Alcohol wipes
	3. Sterile field (may use 4x4 sterile gauze)
	4. Sterile flush solution (see Catheter Specific Flushes - Attachment C)
	5. 10mL Sterile normal saline filled syringe
	6. 1 neutral displacement connector for each lumen.
Blood Specimen Collection	1. Non-sterile gloves (sterile gloves and sterile field for blood cultures)
Discus operation concentration	2. Mask and goggles or full face shield
	3. Alcohol wipes (3) or chlorhexidine swab
	4. One 10 mL luer lock syringe for blood waste
	5. Luer lock syringe(s) for blood specimen collection as provided by phlebotomist
	or-safety vacutainer blood collection device
	6. Patient lab identification labels
	7. Vacuum blood specimen tubes as provided by phlebotomist
	8. Plastic bag with patient labels for ACS and Telemetry morning blood draws
	9. 10mL luer lock syringe with 10ml sterile normal saline
	10. Sterile flush solution as appropriate (see Catheter Specific Flushes -
	Attachment C)
	11. Neutral displacement connector
Dressing Changes	Obtain central line dressing change kit from supply Pyxis.
Accessing or De-accessing	1. Non-sterile gloves
Implantable Venous Ports	2. Mask and goggles or full face shield
Implantable venous i ons	3. Alcohol wipes
	4. Sterile drape
	5. Sterile gloves
	6. Use only safety, non-coring needles to access implanted port, 7. Extension tubing per patient needs for length and gauge.
	8. Neutral displacement connector attached to extension tubing
	9. 10mL syringe filled with sterile normal saline
	a. Chloraprep or Betadine if patient is allergic to Chloraprep or alcohol.
	10. Transparent dressing or 2x2 split sterile gauze and 4x4 or 2x2 sterile gauze.
	11. Steri-strips (optional)
	12. Tape
Damaral Of No. Translat	13. Flush solution as appropriate (See Catheter Specific Flushes - Attachment C)
Removal Of Non-Tunneled	Non-sterile gloves/ Mask and goggles or full face shield
Central Lines (PICCs, Multi- Lumen, Vas Cath)	2. Suture Removal Kit
Luman, vas Galli)	3. Barrier-proof absorbent pad
	4. Regular plastic bag for packaging and dressing disposal
	5. 2x2 gauze, two 4x4 gauze
	6. Large transparent dressing
	7. Chloraprep or Betadine if patient is allergic to Chloraprep or alcohol

TYPE	FLUSH SOLUTION	FREQUENCY	IFIC FLUSHES Attachment C
Central Lines	Normal saline10ml	Q 8 hrs	1. Use preximal port as 1 st choice for drawing blood, routine IV administration, and medication 2. Use Medial port for TPN and may use for medications only if TPN not being given and not anticipated. 3. Distal port as alternative site for blood draw, administration of viscous fluids (i.e. blood products, colloids, albumin), CVP monitoring, and continuous fluid administration.
PICC	Normal saline 10mL	Q-8-hrs	
Patients going home with Central line or PICC	Heparin 20 units per lumen - 2mL of Heparin (10units /mL)	Q 12 hrs	Home Care: Q 24 hrs
Gresheng	Normal saline 10mL	Once a week	
Implanted Port (VA	D)		
Gresheng	Normal saline 10mL	Once a month	
Vita Port	Heparin 300 units 300 units Heparin in pre-filled syringe (100 units/ml) If Heparin pre-filled syringes are unavailable, pharmacy will provide patient-specific syringes.	Once a month	Get a physician order for KVO solution if port must be accessed multiple times. Withdraw 5mL from port to remove heparin if port must be accessed multiple times before flushing with 10mL of normal saline.
Medi-Port	Heparin 500 units - 500 units Heparin in pre-filled syringe (100 units/ml) - If Heparin pre-filled syringes are unavailable, pharmacy will provide patient-specific syringes.	Once a month	Get a physician order for KVO solution if port must be accessed multiple times. Withdraw 5mL from port to remove heparin if port must be accessed multiple times before flushing with 10mL of normal saline.
Vas-Cath	Heparin Concentration 1000 units/mL Check number on venous port Instill that exact number in mL of heparin using the 1000 units/mL concentration (i.e. 1.6=1.6mL, 1.7=1.7mL, 1.8=1.8mL).	Once a week If not being accessed for dialysis	1. Only the Veneus (blue port) port may be accessed and a Physician's order is required before use. 2. Veneus port must be clamped before syringes are connected or withdrawn. 3. Accessing — MUST ASPIRATE HEPARIN BEFORE USE. Using a 10mL syringe, remove 5mL of blood from the veneus port and discard (7mL if drawing PT and/or PTT). Then port can be accessed. 4. De-accessing — Each Vas Cath/Permacath have a number located on the veneus port that is the number of mL of heparin to be instilled when heparinizing the port (i.e. 1.6,1.7, 1.8)



OUTPATIENT INFUSION CENTER - OCEANSIDE POLICY MANUAL

ISSUE DATE: 032/13 SUBJECT: HOSPITAL ADMISSION FROM THE

CENTER

REVISION DATE: 03/13

Department Approval:	06/16
MEDICAL/DEPARTMENT:	3/13
DIRECTOR APPROVAL:	3/13
Division of Oncology Approval:	03/17
Pharmacy and Therapeutics Approval:	07/17
Medical Executive Committee Approval:	08/17
Professional Affairs Committee Approval:	
Donal of Discotors Assessed	00/40

Board of Directors Approval: 03/13

A. PURPOSE:

1. This policy delineates the procedure for an unplanned admission to the hospital directly from the **Outpatient Infusion Center (Center)**.

B. **POLICY:**

1. Patient admissions to **Tri-City Healthcare District (TCHD)**the hospital from the Center will be done in a safe and efficient manner. The Center Medical Director will discuss the recommendation to admit the patient with the patient/family and the patient's primary physician/**Allied Health Professional (AHP)**.

C. **PROCEDURE:**

- Upon evaluation by the Center Medical Director, if admission is deemed necessary, orders for admission will be generated.
 - a. The Center Medical Director will contact the patient's primary physician/AHP to discuss his/her recommendation to admit the patient (if the patient is not triaged to the Emergency Room).
 - b. If the primary-physician/AHP concurs, the patient will be admitted under the care of the primary-physician/AHP.
 - c. The admitting department/nurse will be notified immediately by the support staff/receptionist about the pending admission.
 - d. A copy of pertinent medical, demographic and treatment information will be provided.
 - e. The **Registered Nurse** (RN)/case manager will provide a verbal report to the unit nurse to ensure continuity of care.
 - f. The RN/case manager will act as liaison between the hospital and the family and answer any questions that might arise about the unplanned admission.
 - g. If the patient is not accompanied by family or significant other, the RN/case manager will make the appropriate notifications.
 - h. If the patient is a resident of an extended care facility, the RN/case manager will notify the director of nursing or designee about the pending admission.
 - i. The surgeon and/or the surgeon's office will schedule any surgical procedures planned during the hospital admission.
 - j. The patient will be kept in the Center and closely monitored until notified by the hospital admitting department or designated nursing unit. After clinic hours, the nursing supervisor will provide instructions for patient disposition.

Women's & Children's Services Policy Manual, NICUOutpatient Infusion Center Admission & Discharge Criteria for the NICUHospital Admission from the Center Page 2 of 2

- k. The RN/case manager will coordinate the transfer of the patient to the designated nursing unit with a member of the Center staff and transport personnel, until the designated nursing unit officially receives the patient.
- I. If the patient is unstable and cannot be admitted immediately to an acute care bed, the patient will be transferred to the ER after the ER has been notified.

Tri-City Me	dical Center	Distribution:	Outpatient Infusion
PROCEDURE:	OUTPATIENT SUMMARY LIST P	ROCED DEL	ETE – No longer required
Purpose:	To provide ongoing documentation	for cont	LIL - No longer required
Supportive Data:	This process is unique to Tri-City N	ledical Center	and is not included in Perry & Potter.
Equipment:	Outpatient Summary List Form 61	35-1002	

A. <u>POLICY</u>: Tri City Medical Center is committed to providing continuity of care to the outpatient population. The Outpatient Summary List (OPSL) or Inpatient/Outpatient Summary List in Cerner will facilitate this continuity of care over a period of time by keeping current information regarding patient's diagnoses, procedures, medications, and allergies. This information will be available to all caregivers and is quickly and easily available to staff.

B. PROCEDURE:

- The OPSL or Inpatient/Outpatient Summary List in Cerner will be used in the following areas:
 - a. Outpatient Chemotherapy
 - b. Outpatient Infusion Center
 - c. Special Procedures Recovery Area (SPRA)
 - d. Cath Lab
 - e. Interventional Radiology
 - f. Dialysis Unit (4 Pavilion)
- 2. Areas that utilize the paper OPSL:
 - a. The registered nurse will complete the Outpatient Summary List (Form #6185-1002) by the patient's third visit (may be completed earlier).
 - At the completion of the visit, the OPSL will be sent to Medical Records with the patient's medical record and a copy made and placed in unit file.
 - c. At each subsequent visit, the registered nurse will retrieve the copy of the OPSL from the unit file and update. Any changes will be lined out with a single line, and additions made as appropriate. The RN shall sign/date the form.
 - d. At the completion of the visit, a copy is made of the revised OPSL and placed in the unit file. The revised original shall be sent to Medical Records along with the discharged encounter.
 - Units will purge the OPSL file quarterly by shredding.
- Areas that utilize the Cerner Inpatient/Outpatient Summary List will have information automatically populated on this list in the following way:
 - a. The Outpatient History form will be completed for each encounter which updates the problem list, surgeries and procedures, allergies as well as other key information.
 - b. The Medication History will be completed for each encounter.
 - c. Key data on the Inpatient/Outpatient Summary List will carry forward between patient encounters.
- 4.1. Other outpatient units not addressed in this procedure will develop and maintain their own forms per their unit specific procedures.

Department Review	Division of Oncology	Pharmacy and Therapeutics	Medical Executive Committee	Professional Affairs Committee	Board of Directors
03/13	03/17	07/17	03/13, 08/17		03/13



OUTPATIENT INFUSION CENTER-OCEANSIDE POLICY MANUAL

ISSUE DATE: 03/13 SUBJECT: PATIENT DISCHARGE

REVISION DATE: 03/13

Department Approval:	06/16
MEDICAL/DEPARTMENT:	3/13
DIRECTOR APPROVAL:	3/13
Division of Oncology Approval:	03/17
Pharmacy and Therapeutics Approval:	07/17
Medical Executive Committee Approval:	08/17
Professional Affairs Committee Approval:	
Board of Directors Approval:	03/13

A. **PURPOSE:**

To establish the requirements for patient discharge from the Outpatient Infusion Center (Center).

B. **POLICY:**

All Infusion-Center patients will be assessed prior to discharge and results documented in the patient's medical record.

C. **GENERAL GUIDELINES:**

- Patients will be discharged from the Infusion-Center when the following criteria are met:
 - Stable vital signs. a.
 - Free from signs and symptoms of adverse reactions including severe nausea/vomiting.
- 2. Patients should have adequate muscular strength, endurance, functional capacity and body composition for activities of daily living and occupational needs, or have assistance for these activities at home.
- 3. Patients should have satisfactory understanding of the following:
 - Basic pathophysiology of their disease and treatment.
 - Medication information including possible adverse effects. b.
 - Contact information for the Center and for treating physician.
- 4. Patients will be given printed discharge instructions.
- 5. A discharge summary will be sent to the referring physician/Allied Health Professional upon completion of treatment.



OUTPATIENT INFUSION CENTER-POLICY MANUAL

ISSUE DATE:

032/13

SUBJECT: PHYSICIAN ORDERS / REQUEST

FOR SERVICES ORDERS

REVISION DATE: 03/13

Department Approval:	06/16
MEDICAL/DEPARTMENT:	3/13
DIRECTOR APPROVAL:	3/13
Division of Oncology Approval:	03/17
Pharmacy and Therapeutics Approval:	07/17
Medical Executive Committee Approval:	08/17
Professional Affairs Committee Approval:	
Board of Directors Approval:	03/13

A. **PURPOSE:**

This policy defines the circumstances in which a physician/Allied Health professional orders or requests for services to the Outpatient Infusion Center (Center) Clinic.

B. **POLICY:**

- Only physicians/AHPshealthcare professionals granted hospital medical staff privileges may provide written, telephone or verbal orders for patients being seen at the CenterClinic.
- 2. The clinical staff will take orders only from the CenterClinic physician/AHP.
- 3. Any treatment/procedure may not be performed without the physician's/AHP's written, verbal or telephone instruction unless defined by policy and/or falls within the scope of nursing practice, as mandated by the State of California.
- 4. Orders for patients not being seen by the physicians/AHPs at the CenterClinic may not be accepted or implemented by the clinical staff.
- 5. Hospital policy will be followed when implementing physician's/AHP's orders.

C. **PROCEDURE:**

- When the physician/AHP is on site, orders will be written and signed by the physician/AHP after each clinic visit.
- 2. Verbal orders may be taken by the licensed clinical staff at the direction of the Centerelinie physician/AHP caring for the patient in an emergent situation only.
- All physician/AHP orders will be reviewed noted by a registered nurse according to Tri-City 3. Healthcare District (TCHD)hospital policy.



PHARMACY-MANUAL

ISSUE DATE:

09/11

SUBJECT: Transdermal Fentanyl Patch

Prescribing and Use

REVISION DATE: 03/15

POLICY NUMBER: 8390-6020

Departmental Approval:

Pharmacy & Therapeutics Committee Approval:

Medical Executive Committee Approval:

Professional Affairs Committee Approval: Board of Directors Approval:

05/1507/17

10/11. 05/1507/17 11/11, 07/1508/17

08/15 08/15

A.

To provide a guideline summarizing safe use practices to reduce the preventable harm to patients in the hospital setting.

POLICY: B.

- Due to the Food and Drug Administration (FDA) black box warning, this policy and procedure restricts prescribing to opioid-tolerant patients for the management of persistent, moderate to severe chronic pain that requires continuous, around the clock opioid administration for an extended period of time AND cannot be managed by other means such as nonsteroidal antiinflammatory drugs, opioid combination products, or immediate-release opioids. Fentanyl patch use in non-opioid tolerant patients has resulted in fatal respiratory depression.
- 2. Fentanyl patches are not to be used to treat sudden, occasional or mild pain, or pain after
- 3. Fentanyl patches should not be prescribed for opioid naïve patients receiving comfort care measures or end of life management Patients must meet the Tri-City Medical Center Criteria for use of Fentanyl Transdermal System (see appendix II) and follow dosing guidelines in order to receive fentanyl patches.

C. PROCEDURE:

- Prescribing:
 - Upon receiving an order for fentanyl patches the pharmacist shall evaluate the following:
 - Determine if patient is continuing therapy for chronic pain. i.
 - ii. Determine if the patient is opioid tolerant, defined as:
 - 1) Taking oral morphine 60 mg/day or oral hydromorphone 8 mg/day or oral oxycodone 30 mg/day OR (another opioid at a dose comparable to a fentanyl patch see appendix I) for 7 days or longer.
 - Determine if the patient has any absolute contraindications for use: iii.
 - Patients who are not opioid tolerant as defined above. 1)
 - 2) Management of postoperative pain.
 - Management of mild pain or intermittent pain. 3)
 - Management of acute pain or if opioid analgesia is only needed for a 4) short period of time (less than 7 days).
 - Determine if the patient has any relative contraindications for use: iv.
 - Concomitant use with ketoconazole, erythromycin, nefazodone, diltiazem 1) or grapefruit juice requires careful monitoring and may require adjustment in fentanyl dosage.

- 2) Transdermal fentanyl may not be appropriate for patients with fever, diaphoresis, cachexia, morbid obesity, and ascites, all of which may have a significant impact on the absorption, blood levels, and clinical effects of the drug.
- b. Pharmacist will then verify the following and if necessary, change dose of fentanyl patch based on Fentanyl Dose Conversion Guideline:
 - i. Fentanyl patch is prescribed at the lowest dose needed for pain relief.
 - ii. First-time doses (new starts) should not exceed 25mcg/hr unless recommended by pain specialist or approved by Clinical Manager. Fentanyl patch 12 mcg/hr should be considered for elderly or frail patients.
 - iii. Consider concomitant opiates and other medications known to have additive CNS or respiratory depression effects in evaluating the appropriateness of the dose.
 - 1) Discontinue or taper all other around-the-clock or extended release opioids when initiating therapy with fentanyl transdermal patch.
 - iv. In selecting an initial dose, attention should be given to the following:
 - 1) Daily dose, potency, and characteristics of the opiate the patient has been taking previously.
 - 2) Reliability of dose conversion guidelines to predict the potency of the fentanyl dose needed.
 - 3) Patient's medical status.
 - 4) To account for incomplete cross-tolerance, a 25% dose reduction is needed when switching among opiates in patients whose pain is well controlled. No reduction is necessary in patients with poorly controlled chronic pain. For patients who have acute pain but whose chronic pain is otherwise controlled, a 25% dose reduction is still needed.
 - v. Frequencies of q48h are generally not recommended.
 - 1) Frequencies of Q48h may be appropriate for a small number of adult patients and may be evaluated on a case-by-case basis. Such frequencies will not be allowed for new starts unless approved by the Clinical Manager.
 - vi. During dose titration, increasing dosages shall not be made prior to 72 hours after initiation of therapy, and not prior to 6 days after dose changes.
 - 1) Titrate dose based on the daily dose of supplemental opioids required by the patient on the second or third day of the initial application.
 - Dose should be increased in 25 mcg increments. Larger increments may be considered for some patients on high doses if prescribed and followed by pain specialist.
 - 3) Dose increases are not appropriate for patients who have acute pain but whose chronic pain is otherwise controlled. Such pain should be managed by appropriate use of breakthrough analgesia.
 - vii. When discontinuing transdermal fentanyl and not converting to another opioid, use a gradual downward titration, such as decreasing the dose by 50% every 6 days to reduce risk of withdrawal symptoms.
 - 1) For disposal of fentanyl patches see Patient Care Services Controlled Substances Management Policy.
- c. The pharmacist reviewing the order will document the following:
 - i. Verification of inclusion criteria.
 - ii. Initial dose and date/time of initiation.
 - iii. Validation of inpatient and outpatient drug dosing history (including last refill information).
 - iv. Any potential drug interactions.
 - v. Discussions with prescriber, if any.
- 2. Dispensing and Labeling:

Pharmacy-Manual Transdermal Fentanyl Patch Prescribing and Use Page 3 of 3

- a. Fentanyl patches will been set up as a patient specific medication.
- b. Do not cut patch warning will be placed in MAR notes.
- c. Tall man lettering will be used fentanyl.

3. Monitoring:

- a. Patient monitoring for opioid related side effects will be performed by nursing staff as per the Pain Management Patient Care Services Policy.
- a. Pharmacist will assess for signs and symptoms of opioid-related side effects (confusion, sedation, respiratory depression, hemodynamic instability) throughout the use of the fentanyl patch or until patient discharge, with special emphasis on the initial 24 hours after patch placement or after dose increases.
- b. If a patient is showing symptoms of excessive opioid-related side effects (respiratory distress; shallow breathing; tiredness; extreme sleepiness, or sedation; inability to think, talk or walk normally; feeling faint, dizzy, or confused)
 - i. Notify the patient's primary Registered Nurse or call a Rapid Response based on the patient's condition.
 - ii. Contact provider for orders to remove/adjust dose of the fentanyl patch and/or adjust breakthrough pain medication. Upon discontinuation, approximately 17 hours are required for a 50% decrease in fentanyl levels.

D. RELATED DOCUMENT(S):

- 1. Fentanyl (Duragesic) Dose Conversion Guidelines
- 2. Tri-City Medical Center Criteria for Use of Fentanyl Transdermal System
- 3. Patient Care Services Controlled Substances Management Policy

E. REFERENCE(S):

- ISMP Medication Safety Alert! Community/Ambulatory Care Edition. Volume 13, Issue 3. March 2014
- 2. Acute Care ISMP Medication Safety Alert! Ongoing, Preventable Fatal Events with Fentanyl Transdermal Patches are Alarming! June 28, 2007.
- CHA Medication Safety Committee High Alert Medication Guideline- Fentanyl Transdermal Patch. April 2011.
- 4. Grissinger, Matthew. Inappropriate Prescribing of Fentanyl Patches is Still Causing
- 5. Alarming Safety Problems. Pharmacy and Therapeutics. 2010; 35(12): 653-654.
- 6. Lexicomp, Inc. (Lexi-DrugsTM). Lexicomp. April 27July 5, 20175.



PULMONARY SERVICES

ISSUE DATE:

08/97

SUBJECT: PULMONARY - SCOPE OF

SERVICES

REVISION DATE(S): 08/97, 01/00, 09/03, 08/06, 09/08,

09/09, 11/11, 02/17

Department Approval:

03/17

Pharmacy and Therapeutics Approval:

n/a

Medical Executive Committee Approval:

08/17

Professional Affairs Committee Approval:

Board of Directors Approval:

01/10, 05/12

A. **OVERVIEW OF THE DEPARTMENT:**

The department of pulmonary services provides diagnostic and therapeutic services to inpatients, outpatients, and emergency department patients under the direction of a licensed pulmonary physician. Services are provided to neonates, infants, adolescents, adult and geriatric age groups. Service settings include all hospital areas. Pulmonary services proved provide a 24-hour/7 day service designed to meet the needs of our patients.

DIAGNOSTIC SERVICES INCLUDE: В.

- Pulmonary function testing (outpatients scheduled 2 days-3 days/week: Tuesday-Wednesday-Thursday and inpatients as ordered).
- 2. Non-invasive oxygen assessment (Pulse Oximetry).
- 3. Home oxygen assessment.
- 4. Blood gas sampling and analysis.
- 5. Sleep screening (limited sleep study-screen-inpatients only).
- 6. Bronchoscopy.
- 6.7. CPAP set up and education
- EKGs.

C. THERAPEUTIC SERVICES INCLUDE:

- 1. Patient pulmonary assessment.
- 2. Patient respiratory education.
- Medical gas administration. 3.
- Aerosol therapy. 4.
- 5. Hyperinflation therapy.
- Pulmonary hygiene. 6.
- 7. Airway maintenance and support.
- 8. Ventilatory support.
- 9.
- Exception: Full sleep studies are not performed at TCMC. Patients are referred to Palomar or Scripps.

PROVIDERS OF SERVICE: D.

All providers of respiratory therapy are appropriately oriented to the department and are licensed as required by law. Respiratory Care Practitioners (RCPs) acquire additional training and continuing education to ensure the proper care of patients. RCPs function under the direction of a medical director who specializeds in pulmonary medicine. The medical director

- acts in that role for one-two years as described in the medical center by-laws. RCPs also function under the direction of an operations manager and director.
- 2. The pulmonary services department staff work in 12-hour shifts. The number of staff scheduled each shift is based on the total workload calculated from the Respiratory Therapy Workload Summary report. RVUs or "sums" which are reviewed as part of the department information management system, "Medi-Serve."
- 3. Qualified RCPs are available 24 hours a day, 7 days a week on site. RCPs re4port to a lead therapist or shift supervisor on both shifts.
- 4. Additional Mmembers of the pulmonary management services team include the following:
 - 3. RCP coordinators:
 - a. Clinical educator.
 - a. Pulmonary Manager
 - b. ICU coordinator Dayshift supervisor(s)
 - c. Nightshift supervisor(s).
 - d. Clinical Educator
- 4.5. The role of the RCP at Tri-City Medical Center and additional pulmonary support staff is described in the job descriptions and policies and procedures. The department of pulmonary services is composed of professional, technical, clerical, and support staff in the following categories:
 - a. Director
 - b. Ops-Operations /Clinical manager
 - c. Educator
 - d. CoordinatorSupervisors
 - e. Leads
 - **f.d.** Registered/Ceertified pulmonary function technologists
 - g.e. Registered respiratory therapists (RRTs)
 - h.f. Certified respiratory therapists (CRTs)
 - g. Cardiopulmonary assistants (equipment technicians)
- i.6. Job descriptions are on file for each of the above job categories.

E. EQUIPMENT:

1. The pulmonary services department provides services utilizing medical equipment that is maintained in proper operational condition per preventative maintenance schedules and manufacturer's recommendations. Equipment inventory includes disposable and non-disposable equipment.

F. STANDARDS AND PRACTICE GUIDELINES:

- 1. Effective and efficient patient care is provided based on current standards of respiratory care and practice. TCMC pulmonary services adheres to federal and state regulatory imperatives and standards including the Respiratory Care Practice Act, Title 22, and Title 17, Center for Disease Control (CDC) and OSHA, and JCAHO. Patients can expect care that is delivered in a manner consistent with the American Association of Respiratory Care (AARC) Guidelines for Therapy whereby patients are assessed so that individual needs are met. The patient is evaluated to ensure that therapy is appropriate, indicated, and objectives clearly defined.
- 2. Patients and patient families can expect to be treated with dignity and respect (per "Patients' Rights") by the RCPs who also provide education and explanation of services for their customers.
- In addition to the national guidelines, policies/procedures and protocols are based on expert consensus, documentation team review and community standards. Policies and procedures are reviewed every year and revised as needed to accommodate new evidence, standards, and/or guidelines. Policies are discussed among the management team with input from RCPs then the hospital documentation team before they are finalized. Final versions are communicated to the staff through email, staff meetings, notes on bulletin boards, and "lunch" and "dinner" meetingsand daily huddles on each shift.

| Respiratory Care ManualPulmonary Services
Pulmonary – Scope of Services
| Page 3 of 3

3.4. All policies and procedures are posted online after submitting to house wide review and board approval.



PULMONARY SERVICES

SUBJECT: Respiratory Medication Administration

ISSUE DATE: 05/09

REVISION DATE(S): 09/09, 01/12, 06/15

Department Approval:

09/09. 1/12.- 7/1508/16

Medical Staff Pulmonary Division:

04/17

Pharmacy and Therapeutics Approval:

07/17

Medical Executive Committee Approval:

08/17

Professional Affairs Committee Approval:

Board of Directors Approval

A. DEFINITION(S):

1. RCP- Respiratory Care Practitioner

B.A. POLICY:

- 1. Respiratory medication treatments will be rendered as close to the Respiratory medication standard times as possible, although the fact that a single RCP may be assigned as many as 10-12 patients a day makes it impossible to provide all treatments at the exact prescribed times. Patient diagnostic testing, meals trays, Codes, Rapid Response calls and urgent PRN (as needed) calls may impact the times that therapy is being provided.
- 2. The **Respiratory Care Practitioner** (RCP) may stagger times to keep the intervals between treatments appropriate.
- 3. The general expectation is that treatments will be given within one hour before or after the targeted treatment scheduled time.

G.B. PROCEDURE:

- 1. The RCP will stay with the patient during the treatment with the exception being the Emergency department and ICU where close monitoring is provided by both RN's and RCP's.
- 2. Patients may be treated concurrently if they are in the same room with the RCP using proper infection control techniques.
- 3. The RCP's may only review medications for inhalation.
- 4.3. The RCP must compare the Medication Administration Record (MAR) and the medication shown on the Care Mobile device to the physician's medication order to ensure accuracy.
- 5. The Pharmacist is the primary review of the physician's medication orders and then the RCP or RN is the second-licensed verification on inhalation medications.
- 6. RCP's may perform the Clinician review on the Care Mobile device for inhalation medications.
- 7.4. Below is the table listing the Respiratory therapy Medication times:

Rx Frequencies	Times Given
RT Daily (1/Day)	0900
RT QAM (1/Day)	0900
RT BID (2/Day)	0900-2100
RT TID (3/Day)	0900, 1500, 2100
RT QID (4/Day)	0800, 1200, 1600, 2000
RT Q4h (Every 4 hours)	0700, 1100, 1500, 1900, 2300, 0300
RT Q6h (Every 6 hours)	0900, 1500, 2100, 0300
RT Q8h (Every 8 hours)	0800, 1600, 2400
RT Q12h (Every 12 hours)	0900, 2100
W/A (While awake)	Rx will be given routinely during daylight hours
•	0700-2000. If the patient requires therapy during
	the night, it may be given.
PRN (As needed)	Patient request/RN or RCP judgment.

REHABILITATION SERVICES

SUBJECT:

Emergency Care - 2124 El Camino Real Outpatient Services

ISSUE DATE:

07/91

REVISION DATE(S): 02/94, 09/97, 10/00

Department Approval:

08/16

Department of Medicine Approval:

n/a

Pharmacy and Therapeutics Approval:

11/0

Medical Executive Committee Approval:

n/a

Professional Affairs Committee Approval:

n/a

Board of Directors Approval:

01/15

ISSUE DATE: 7/91

SUBJECT: EMERGENCY CARE - OUTPATIENT SERVICES

2124 El Camino Real, Oceanside

REVISION DATE: 2/94, 9/97, 10/00 **REVIEW DATE:** 2/03, 1/06, 1/09, 4/12

STANDARD NUMBER: 1504

CROSS REFERENCE:

APPROVAL: BOARD OF DIRECTORS APPROVAL: 01/15

This Policy / Procedure applies to the following Rehabilitation Services' locations:

—4002 Vista Way, Oceanside, CA

2124-El Camino Real-Suite 100, Oceanside, CA

6250 El Camino Real, Carlshad CA

3861 Mission Ave B25, Oceanside, CA

A. PURPOSE:

To provide emergency services to patients in the Outpatient Rehabilitation Services Department located at 2124 El Camino Real

B.A. POLICY:

1. All emergency medical, fire and law enforcement situations occurring at the Rehabilitation Services Outpatient Department and the Wellness Center will be provided by city emergency response systems. of the City of Oceanside.

C.B. PROCEDURE:

- 1. In case of any medical, fire or law enforcement emergency, staff members will initiate appropriate interventions such as assessing vital signs, initiating CPR, RACE, etc., as indicated per Departmental Policy, and dial 911 for assistance, specifying outpatient location.
 - 1.a. Notify main hospital for fire or other emergencies.
- 4.2. Appropriate documentation of each incident will be completed by Rehabilitation Staff members, including notifying the patient's physician when the incident involves a patient.
 - a. Staff members, including notifying the patient's physician when the incident
- b. involves a patient.
- 2.3. Follow-up on patient status/outcome is documented in the medical record.



Delete- no longer needed

REHABILITATION SERVICES

SUBJECT:

Movies/Videos -- TR

POLICY NUMBER: 902

ISSUE DATE:

09/91

REVISION DATE(S): 8/97, 4/12, 5/12

Department Approval:

08/15

Department of Medicine Approval:

n/a

Pharmacy and Therapeutics Approval:

n/a

Medical Executive Committee Approval:

n/a

Professional Affairs Committee Approval:

Board of Directors Approval:

ISSUE DATE: 9/91

SUBJECT: Movies/Videos -- TR

REVISION DATE: 8/97, 4/12, 5/12

STANDARD NUMBER: 902

REVIEW DATE: 2/03, 1/06, 1/09

CROSS REFERENCE:

APPROVAL:

This Policy / Procedure applies to the following Rehabilitation Services' locations:

4002 Vista Way, Oceanside, CA

2124 El Camino Real, Suite 100, Oceanside, CA

6250 El Camino Real, Carlsbad CA

A. PROCEDURE

1. The opportunity will be provided for patients to view a variety of movies and/or videos.

B. GOALS

- 1. To increase sensory stimulation.
- 2. To increase socialization skills.
- 3. To provide an opportunity for passive participation.
- 4. To stimulate environmental awareness.
- 5. To provide opportunities for educational development to assist with a healthy lifestyle.

C. PROCEDURE

- 1. Movies/videos shall last from 30 minutes to 2 hours (may include several short videos or 1 full-length video).
- 2. Patients will be encouraged to remain quiet throughout the entire program.
- 3. Patients will have input into the selection of the movies/videos via individual suggestions and group discussions.
- 4. Movies/videos shall be appropriate to age, group, and patient-interests.
- 5. Following the movie/video, discussion will occur-regarding the content and information shared.
- 6. Movies/videos may be rented by Therapeutic Recreation staff and/or brought in by family members.

 All movies/videos must be approved by staff prior to viewing.

D. MATERIALS

1. These may include VCR, DVD, computer, monitor, electrical outlet, video/movie, or other gaming/DVD playing console. Refreshments are optional.

Rehabilitation Services Movies/Videos -- TR Page 2 of 2

E. CRITERIA

- 1. Patients must be free from other scheduled programming.
- 2. Patient must be able to sit quietly for long periods of time (11/2-2 hours).
- 3. Patients who wander or exhibit behavioral problems must attend with staff-supervision.

F. ADAPTATIONS

1. Sound will be monitored for those clients who are hard of hearing.

G. GROUP SIZE

1. Limited only by size of room.

H. EVALUATION

1. Patient response to movies/videos shown will be documented in weekly progress notes.

PROCEDURE:
DIAGNOSIS:
ALLERGIES:
STATUS: INPATIENT OUTPATIENT CODE STATUS: Full No Resuscitation for hospital duration* *Requires notation in Progress Notes.
MEDICATIONS: Given by MD in CCL: □ Lidocaine 1% injectable for local anesthetic □ Sedium bicarbonate 4.2% injectable with anesthetic □ Heparin 1,000 units / mL,10 mL to scrub table □ Cefazolin (Ancef 1) gram in 250mL of normal saline for pocket irrigation to scrub table □ Nitroglycerin 100 mcg / mL to scrub table □ Nicardipine 100 mcg / mL to scrub table □ Other:
Given by RN in CCL: Cefazolin (Ancef) 42 gram IVPB x 1 dese once Clopidogrel (Plavix) 600 mg PO x 1 dese once Prasugrel (Effient) 60 mg PO x 1 dese once Ticagrelor (Brilinta) 180 mg PO x 1 dese-once Bivalirudin (Angiomax) bolusmg/kg and drip atmg/kg/hour Eptifibatide (Integrilin) 180 mcg/kg bolus (max 22.6 mg) Q 10 minutes x2 deses times two doses Eptifibatide (Integrilin) drip at □ 2 mcg/kg/min (max 15 mg/hr) OR □ 1 mcg/kg/min (max 7.5 mg/hr) Meperidine (Demerol) 12.5 mg – 100 mg IVP Q 5 minutes PRN Procedural Pain/Sedation as directed by MD Fentanyl (Sublimaze) 25 mcg – 100 mcg IVP Q 5 minutes PRN Procedural Pain/Sedation as directed by MD Morphine 2 – 10 mg IVP Q 5 minutes PRN Procedural Pain/Sedation as directed by MD Midazolam (Versed) 0.5 mg – 5 mg IVP Q 5 minutes PRN Pain/sedation as directed by MD Naloxone (Narcan) 0.4 mg IVP on call to reverse sedation post procedure if needed Flumanzenil (Romazicon) 0.2 mg IVP on call to reverse sedation post procedure if needed Other:
□ Other:
□ Other:
□ Read Back all T.O./V.O.orders
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8711-4010 8711-4536 (Rev. 12/10)

Nurse's - Signature

CARDIAC CATH LAB MEDICATION ORDERS Page 1 of 1

Date

PHYSICIAN'S ORDERS

Time

Physician's - Signature

Affix Patient Label

Date

Time

	Tri-City Medical Center		Carlsbad '	Wellness Center	•		
	4002 Vista Way, Oceanside CA 92056		6250 El Ca	amino Real, Carls	bad CA 92008		
	Phone: 760-940-3098, Fax 760-940-4056		Phone: 760	0-476-2905, Fax	760-931-3163		
Pa	itient Name:		D(OB:		_	
Ho	ome Phone:	Cell: _					
DI	AGNOSIS:			Date of Onset	or Intervention	:	
	Acute Myocardial Infarction STEMI (within 1 yes Non-STEMI (within 1 year of infarction) Coronary Artery Bypass Graft surgery Stable Angina Pectoris Heart Valve Repair or Replacement CHF (EF documented < 35%) Percutaneous Transluminal Coronary Angioplas PTCA with Coronary Artery Stenting Heart Transplant Phase IV Supervised Maintenance Program (O COGRAM OPTIONS / TREATMENT PLAN: Phase II Continuous Telemetry Monitored Carasessions in 12-18 weeks: Initial Evaluation Nursing Assessment Progressive exercise training 3 times per hand weights, steps/recumbent stepper Education to promote an active healthy I	sty ceanside diac Reha r week, 30 , elliptical,	site only) b, duration 0-60 minute	based on patient	lizing treadmill,		
	FENSITY: Patient will be exercised to tolerance with the fo □ None □ Based on Stress Test, completed on			art Rate Range: _ ximum Heart Rat	 e:	_	
Re	strictions:						
	My patient does not require a graded exercise to My patient has had a graded exercise test and My patient is able to participate in the cardiac monitored for 3 visits. This option is self-pay, a responsibility of the patient (Oceanside site on	we will fax ehabilitat nd no ins	it to the Ca	ardiac Wellness F ENANCE program	rogram. n, where he/she	will only vill be the	be ECG
	Phase IV Cardiac Rehab Maintenance Program	(Oceans	ide site only	/)			
	☐ Supervised exercise without Telemetry n	nonitoring					
<u> </u>	Read Back all T.O./V.O.orders						
Nurs	se's – Signature Date	Time	Physician's -	Signature		Date	Time
(2)					Affix Patient Label		

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CARDIAC REHABILITATION PHYSICIAN REFERRAL ORDERS Page 1 of 1

PHYSICIAN'S ORDERS

DIAGNOSIS:	
DIAGNOSIS:PROCEDURE:	
ALLERGIES:	
ADMIT TO: ☑ Labor & Delivery	
•	n for hospital duration*
*Requires notat	tion in Progress Notes.
ASSESSMENT: ☐ Electronic Fetal Monitoring ☐ Check	FHT in OR prior to surgery, before abdominal skin prep
DIET: ☐ NPO after midnight ☐ Regular Diet	
LAB/DIAGNOSTICS: ☐ Comprehensive Metabolic Panel (C12) ☐ CBC	
☐ Type and screen ☐ Type and cross☐ Capillary Blood Glucose upon admission for pati☐ Other:☐	ents with Diabetes
☐ Other:	
MEDICATIONS: ☐ Antibiotic ☐ Cefazolin (Ancef) 2G IVPB to be given by anesthes ☐ Cefazolin (Ancef) 3g IVPB for patients weighing g	iologist before cut prior to incision. greater than or equal to 120kg. To be given by
anesthesiologist prior to incision. ☐ Clindamycin (Cleocin) 900 mg IVPB to be given by	anesthesiologist prior to incision.
IV:☑ Start IV with 18 gauge catheter.☑ Infuse Lactated Ringers at 500 mL per hour X 2 hour	rs, then at 125 mL per hour.
CONSULT:	
☑ Notify anesthesia of patient's admission.	
TREATMENT:	
Abdominal PrepInsert #16 Foley catheter prior to surgery.	
CONDITIONS:	Page (
 No additional DVT Prophylaxis required at this time Explain: 	□ DVT Anticoagulation Prophylaxis contraindicated.
NON-MEDICATION DVT PROPHYLAXIS:	
☐ Sequential compression device knee high ☐ Bila	
CAUTION IF USING THIS PROTOCOL FOR PRESCRI THAN 100,000/mcL.	BING HEPARIN OR ENOXAPARIN IF PLATELETS LESS
MODERATE TO HIGH RISK (Including general surgery, h	ip fracture surgery, total hip replacement, and total knee
☐ Read Back all T.O./V.O.orders	
Nurse's - Signature Date Time	Physician's – Signature Date Time
(a)	Affix Patient Label
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8711-4010 OB SCHEDULED C-	
DOWNTIME ORDERS	
SHEETS Page 21-of 21	

8711-1118 Revised (06/13)

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- eplacement):

 □ Enoxaparin (Lovenox) 30 mg subcutaneous upon admission.
 □ Enoxaparin (Lovenox) 40 mg subcutaneous upon admission
 □ Heparin 5,000 units subcutaneous upon admission

☐ Read Back all T.O./V.O.order	S				
Nurse's - Signature	Date	Time	Physician's – Signature	Date	Time
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8711-4010	OB SCHEDULEI SECTION DOWNTIME ORD SHEETS				

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